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A Textbook of Psychoanalytically Oriented Psychotherapy

Theory and Technique

SHAKUNTALA DUBE

NEW AGE INTERNATIONAL PUBLISHERS

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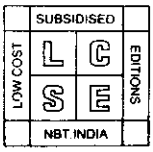

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FOREWORD

There are various methods of psychological treatments in the field of mental health. Prominent among these are simple advice, didactic therapy, environmental manipulation, psychotherapy, behaviour therapies and counseling. Psychoanalytically oriented psychotherapy is the oldest and distinct technique of treatment. Its principles have their roots in the Freudian theory and practice. Over the last 70 years the psychotherapeutic process of treatment and theory have undergone continuous evolution incorporating the cultural ethos of the society where it was practiced. Psychotherapy has its own variants - group therapy, family therapy, couple therapy - which partly evolved keeping in view the needs of those who sought or were referred for treatment and partly, as response to economy of time. Individual psychotherapy, however throughout the world still remains the most common and accepted form of psychotherapy.

In India, historically, Freudian theory, its principles and practice, never got firmly established even though Indian Psychoanalytical Society was formed in Calcutta during the early part of 19th Century and its journal is still published at intervals.

A few psychiatrists in India have attempted to develop frameworks of psychotherapy which were supposed to be culture specifics. These efforts, however did not match with systematic training of psychiatrists or clinical psychologists. They remained mere intellectual exercises, as a body of clinical experience was not built around the formulated theories.

The present author has two special qualifications which are amply reflected in the text. Firstly, the author received supervised training in psychoanalytic techniques, theory and practice in one of the world's reputed training centres in U.S.A. Secondly, the author practised psychotherapy for more than 30 years in a premier medical research and training Institute here in this country. This provided her with an opportunity to

treat not only those who came to Psychiatry department for assistance but also patients from other branches of medical science.

The book reflects the distilled essence of the wide experience of actually working with patients and the interactions with trainee students and colleagues in this Institution. One of the major contribution of the author, reflected in the text, is the demonstration of the fact that human beings are similar all over the world. Their conflicts, anxieties, defenses and principles of therapy are valid cross-culturally. Lastly, it demonstrates that psychotherapy can be successfully practised in a setting where no fees are charged; this a direct contradiction of the established dogma of the field in the West.

This is a book which will be of immense use to both, under graduate and post graduate students. It will provide food for thought to those already in the field. It has been my privilege to work with the author in varying capacities.

28/11/94

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PREFACE

This book is intended to provide subject material on the theoritical basis as well as techniques involved in carrying out psychoanalytically-oriented individual psychotherapy for adults. The tone of the text is by and large clinical. It is based upon the author's own experience in practising this form of psychotherapy without charging fees and it is substantiated by readings from published clinical cum research works of other psychotherapists. Being a teacher it was felt that a text which could provide with accurately written down procedures, principles and techniques involved was required. The emphasis is on the queries made from time to time by the graduates and post-graduates at All India Institute of Medical Sciences, New Delhi. This may be due to controversies regarding the varied approaches and techniques in carrying out psychotherapy. However, the reader should note that at the present state of our knowledge it is neither feasible nor desirable to be so much formalized and structured in the clinical setting.

The book should facilitate understanding of the procedures of psychoanalytically-oriented psychotherapy, how and why Freudian theories originated, why they differed in different periods and places, and what makes them still relevant to the practice of modern Psychiatry and super-speciality of Psychotherapy.

This book neither demands a previous knowledge of psychoanalysis nor the adherence to a particular school but it is recommended to keep an open mind and adopt a professional attitude while practising psychotherapy. In the field of mental health, even a non-medical psychotherapist is required to be ethically bound to serve the patients with the best of one's knowledge and without any ulterior motives.

The text has made a wide use of psychoanalytic terminology, borrowed from national and international sources. An attempt has been made to define technical terms based on the readings listed at the end of the

book. Some illustrative clinical examples have also been given. A trainee in psychotherapy may make use of the references listed for adding to their knowledge. The techniques should be tried out under supervision after reading all the chapters of the book or each chapter separately. A Glossary of the definitions of the terms officially approved by a group of experts is also provided.

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February 28, 1995

Shakuntala Dube

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INTRODUCTION

Purpose and Overview

Psychotherapy varies greatly with the time, the place, the therapist and the patient. This book provides guidelines for carrying out *psychoanalytically oriented psychotherapy*, especially in the settings where medical treatment is usually provided *without payments* being made directly to doctors as they are employed on a fixed salary by governmental organisations/philanthropic institutions. It is based upon the tested knowledge of clinical practice of *psychoanalytic technique* plus the author's clinical experience, gathered since 1971 at the *Department of Psychiatry, All India Institute of Medical Sciences, New Delhi*. Emphasis is on the *technique of individual adult therapy*.

All patients referred were first screened by a trained psychiatrist or some other clinical consultant who followed them up for adjunct drug treatment but not for any physical forms of therapy like Electrical Convulsive Therapy/Psychosurgery. In such a setting, it was important for a psychotherapist to maintain a conceptual framework in conducting his/her work - which required formulation of the goal and duration of treatment, strategies and tactics to be adopted. At the same time maintaining, as a rule of thumb, 'the patient's need of the hour' which decided the subject matter of the session for the therapist to pay attention to, exercising one's own unconscious material coming to the surface through intuition, fantasies, dreams, associations and, above all, 'empathetic sharing' of verbal and non-verbal communications. This necessitated writing down the ways in which a psychotherapist works. Henceforth, the psychotherapist will be referred to in the feminine gender but the same will be applicable to the male therapist as well.

Need for Trained Psychotherapists

Presently there is a dearth of trained psychotherapists in India. Formal training of psychoanalysis or any other form of psychotherapy is not avail-

able, along given guidelines prescribed in the Western world where opportunities of training and published research work on psychotherapy have both progressed rapidly. There is an association between social class, mental illness and willingness to come for psychotherapy. Yet, the preferred ways are to only give practical advice, medication and warmth (Aronson and Overall 1962, Overall and Aronson 1963, Borghi 1968). The lower Socio-Economic Status (SES) patients were generally treated on lowered fees by less experienced/trainees who might neither have understood the communication style nor evolved newer probing strategies needed for such patients *(author's conjecture)*. The research work shows that early-drop-out rate of lower SES patients was associated with factors like lack of congruence between what the patient wanted from the therapist and what the therapist thought should be provided (Cobb 1972).

Studies from India and abroad show that a sizeable population of patients presenting in general hospital setting have significant emotional problems ranging from physical and psychosomatic disorders to other psychiatric disorders. Unfortunately the attending physicians are not trained in diagnosing these problems. Even psychiatrists and other mental health workers like clinical psychologists, psychiatric social workers etc. work on these cases only upto diagnostic formulation. They seldom view their symptoms as a symbolic consequence of the mind's effort to adjust to the various levels of his/her awareness of total 'consciousness'. No doubt, symptoms are emotionally painful and quite distressing to the patients but they serve a practical purpose. They prevent the conscious awareness of thoughts and feelings that, consciously or unconsciously, the patients consider even more frightening and painful. Henceforth, only the masculine gender will be used for both, male and female patients. **Sharing of such intensely emotional experience can be viewed as 'psychotherapy'.** It is a book about psychotherapeutic theory and technique of one person (therapist) trying to help another person (patient) to deal with disabling confusion and mental pain, in the traditional setting of doctor - patient relationship.

Psychotherapy: Theory and Technique

The medical setting has several disadvantages as well as advantages. When a patient is referred for psychotherapy, he is properly investigated for ruling out organic etiology. By the time he is diagnosed to be suffering from functional illness, probably both, the patient and the physician, get exhausted searching for the roots of the problem and trying out the various prescribed drugs. The patient in this process is not only tired but also disillusioned and quite confused about what his illness is. Not that the psychotherapist knows any better about the disease which the patient is suffering from and made him go from one doctor to another. Even when the referral of a patient is accompanied by *a proper labeling of the disease* and *psychodynamics are well formulated*, experience in psychotherapy showed

that patient's complaints were usually not heard carefully by the *busy doctor* or the patient himself tried to hide/repress that information because of his possible surrender to the powerful authority whom he viewed as *'best knower' of the body*. Unlike the Western patients coming for psychotherapy, the Indian patients usually have been found to be more bodily preoccupied, compliant and dependent, as if they lacked introspective ability and the so-called 'psychological sophistication' and suffer from 'dependency syndrome' (Neki 1977). On the *surface* it may seem as if the patients treated on psychoanalytic lines are quite *different* in demographic, economic, intellectual and cultural characteristics. This treatment can be provided only in those countries which are modern and developed (Inkeles and Smith 1974), in the sense that psychoanalysis requires a rejection of traditional social support associated with the 'embeddedness' of the member in his culture, i.e., (1) the extended family, (2) traditional forms of religion, (3) the subordinate status of women. But the patients, who were referred to the author, were traditional as well as modern. They were in the process of individuation of such struggle with the help of social support system; probably they were more willing to sit and talk with self-revelation in therapy. This led to opening of different layers of their consciousness and ended in mutual level of satisfaction, more so in the patient who now understood how to go about in life (especially in coping with stresses and strain) with a greater zest for life. The maladjustment or the cluster of symptoms, called *syndrome* in psychiatric parlance, requires to be dropped and the word *client* seems better suited for patients taken in for psychoanalytically oriented psychotherapy; because the word 'patient' has implications for *interpersonal power* which the psychotherapist of any orientation should leave behind. The therapist has to be sensitive to the issues of power relationships; the patient's perception of the therapist as a separate helpful person, consequent independence and resolution of the *transference* (discussed in Chapter II) are the most important and fascinating aspects of personality change through psychoanalytic psychotherapy.

In this context, the issues of *counter-transference* (described in Chapter II) are of equal importance. In the medical setting, the diagnostic or classificatory schemes are adhered to for purely scientific purposes, since proper diagnosis enables the discovery of the underlying etiology, prognosis and management of a disease which have direct implications for clinical practice. The *Diagnostic and Statistical Manual* of the American Psychiatric Association (1968) and its revisions, as well as *International Classification of Diseases* (WHO) give brief syndromal descriptions of symptoms. The assumption is that the trained psychiatrist, with the knowledge acquired from reading text books and clinical practice, can correctly identify *diseases* thus described. A number of studies have been done to investigate how far psychiatrists agree on their diagnosis of a given patient. Numerous case conferences held every week at the teaching hospitals testify that these results have not been encouraging. Even the broad categories of Psychosis, Neurosis and Personality disorders seem somewhat unreliable al-

though current research work on a number of reliably recognizable syndrome are being carried out (e.g., Lorr et al 1963, International Pilot study of Schizophrenia 1973, Wing et al 1975 and several others). Indeed, oversimplified and a compelling set of connections between symptoms and labeling (no matter how authentic the psychological tests report is, to confirm the clinical diagnosis) and prognosis is likely to prejudice the psychotherapist. A sensitive patient perceives this confusion and perplexity in the treatment situation no matter *whether he does or does not know the diagnosis and what the treatment of psychotherapy consists of.* The diagnostic labeling makes the psychotherapist question whether she is prepared to undertake the case even before psychotherapy begins. It is *essential* for the psychotherapist to determine *how, why and with what perceived notions a patient has come for consultation,* what hopes and fears he brings into a treatment situation and whether his personal characteristics indicate a greater or lesser likelihood of his benefiting from psychotherapy.

There is some research evidence to suggest that some therapists work better than others with patients labeled *Schizophrenic, Borderline personality* etc. With the help of Psychological testing Betz (1967) has attempted to identify such therapists. This research, by no means, is perfect at present. By and large, *psychotherapy of various categories of patients should enrich the clinical experience and counter-transference issues should be viewed as means towards developing improved psychotherapeutic techniques.* In a research oriented medical institute like A.I.I.M.S., one is exposed to several other unresolved difficulties. However, the constant behavior oriented questioning and dialogue with students and colleagues enables one to admit difficulties of a *particular theoretical framework* with which one had found security in the beginning of one's career. The *psychoanalytic technique of psychotherapy,* which this book is oriented to, has been evolved gradually by Freud and later workers who struggled to find ways of effectively helping their patients. Freud was an astute clinician who could discern what was meaningful in the complicated sequences of clinical events following the various technical proceedings he employed. He possessed that complex combination of temperament and character traits that enabled him to be a 'conquistador', an 'adventurer of the mind' and a 'careful scientific investigator' (Jones 1953). Freud had the boldness and inventiveness to explore new regions of thought, vigorously and creatively. When proved wrong, he had the humility to change his technique and theory (Greenson 1967) whereas in the classical Freudians one finds, at times, a tendency to recommend *their procedures* - as if their *personal conviction* was equivalent to validity and *not requiring further empirical verification!* It should be pointed out that there is little public communication about the details of psychoanalytic technique but there is a great deal of private talk between analysts within closed groups or expert teachers and trainees - a fact which makes for esoteric aloofness and also retards scientific progress (Glover 1955). As Greenson (1967) puts it, "The training analysis carried out as part of a professional training program usually leaves a considerable residue of

unresolved transference reaction which restricts and warps the student's development in the field of psychoanalysis''.

In psychoanalytically oriented psychotherapy, *teaching has little importance.* It does not require details to be described especially about *what the therapist actually does when she analyses a patient:* one can say, at the outset, that even excellent standard works on technique written by Freud, Glover (1955), Fenichel (1941), Greenson (1967) are only outlines. Infinite mutiplicity of situations arising in analysis does not permit the formulation of general rules about how the analyst should act in every situation which essentially is *unique with every patient.* In a clinical interaction too many things happen at once and what should be focused upon and probed further depends upon the *working-alliance* established later between the therapist and the patient in the process of treatment when *resistance* (discussed in Chapter II) issues get resolved. Freud (1933) had declared that ''just as in chess only the opening moves and some typical concluding situations are teachable, but not all that goes on in between and comprises the actual analytic work''. However, a basic knowledge of psycoanalytic theory and its major concepts is essential before practicing psychotherapy.

Author's Bias

Despite all these difficulties, after reviewing published research - especially on the *process* of psychotherapy of various theoretical orientations, the choice of adhering to psychoanalytic orientation will become clear to the reader*. It is a theory and technique of treatment *centered around the very things that disturb a patient most.* The patients need and expect understanding from experts of interpersonal skills, which psychotherapy can offer, in response to their call for help. The psychoanalytic therapy derives impetus from two major sources. One is the personal relationship with the therapist and the other is the effort to increase self-understanding or the so called *insight,* which is essential in the psychoanalytic psychotherapy. It is Freud's genius to have clearly recognised so early that, in this complicated emotional relationship, the success depends upon resolution of resistance and transference which are said to be the foundations of psychoanalytic technique. They have been listed in different ways (Chapter II). But the therapeutic process is a single complex phenomenon and has to be viewed as interacting simultaneously with interrelated facets of the therapist and the patient.

The reluctance of psychoanalysts to expose their methods of practice stems from many sources. The most *crucial reason* is that clinical work depends upon many *intimate and personal processes within the therapist.* Psychoanalysis is said to be a lonely profession and as a rule *any other trained observer is not allowed* to scientifically *monitor* this form of psychotherapeutic *process.* But with the advent of video recording it was possible

* It is also based on my own experience as a trainee at Postgraduate Centre for Mental Health, New York, as well as after becoming a teacher and practitioner of psychoanalytically-oriented psychotherapy at A.I.I.M.S.

for Post Graduate Centre for Mental Health, New York, to impart training and to correct our mistakes. At that time (Directorship of L.R. Wolberg 1969-71) the Post Graduate Centre was famous for exposing students to other techniques of psychotherapy. Thus, it allowed *my exposure* to various other modalities like *Group psychotherapy, Family psychotherapy* and even *Behavior therapy* of *Wolpe at Temple University, Philadelphia,* within the short period of my stay of *two years* while undergoing the Adult centre requirements of Personal-analysis and Clinical work (20 hours per week) with a number of supervisory analysts. It should be pointed out that although there has been little public communication of my work - in terms of published research, there has been a great deal of *private talk* and review of my work by psychiatrists, colleagues and students, who had referred the cases to me. They were amazed at seeing the personality changes in these patients in the process of long term/short term individual, group or family psychotherapy with me. At times it was possible for me to *tape record* the entire interview or make detailed notes for reviewing but, later, it was found to be a *tedious process* because it interfered with the *'unhovering' attention* I wanted to provide for my patients. At times, I allowed some serious *students* (who had brought their patients to me with eagerness to learn the process of psychotherapy) to *witness* the entire interview conducted. But few residents had the time and the patience to learn through sitting passively and, later, for *active discussion* even though some patients were more than willing to be observed. I was very keen to discuss what transpired between myself (therapist) and the patient so that it could become the subject matter for discussion on the technique of psychoanalytically oriented psychotherapy. Thus in the existing psychiatry residency program of A.I.I.M.S., where the residents have to be trained in Psychiatry and Neurology as well as in subspecialities of Substance Abuse, Liaison Psychiatry, Child Psychiatry etc. it is not possible to impart training in psychotherapy at this stage of learning.

Despite such constraints, this book echoes the clinical experience and practice as well as my own experience and maturity as a student, teacher and researcher of psychotherapy. It is said that no one can adhere to a particular *theoretical framework* or *modality* in psychotherapy (individual, group, family, couple etc.). It depends on the clinical experience of a therapist, the setting in which therapy is being provided and the type of patients who come for therapy, which necessitates *innovative techniques* and application of various theories of psychotherapy. In this process, the most important are the attitudes and the feelings the therapist has about her patients and the consistency and the skill with which she handles the patients while carrying out therapy.

One abides by *formal commitments* and constraints in the professional psychotherapeutic relationship that seldom characterize other interpersonal relationships, though at times similarities may be found and may be present in any other encounter. Some of the distinctive features of psychotherapeuic interventions are:

(1) The therapist's training allows her to empathize with another person's psychological difficulties far better than others except by the most unusually intuitive and sensitive non-professionals. The trained therapist's technique and skills for communicating this kind of understanding is based upon the scientific knowledge and is within the framework of ethical rules and regulations of the profession.

(2) This professional relationship is *not a mutual relationship.* The interest, needs and welfare of the patient always come first. During the therapy sessions the therapist rarely asks for consideration of her own interest, needs and welfare. It is not that the professional psychotherapist is free of problems or preoccupations, has no feelings towards her patient or does not experience waxing and waning enthusiasm in the course of the treatment. The therapist's self-awareness, facility to postpone immediate need gratifications and willingness to open as a frank and honest person facilitates communication. She conveys that she is not hiding behind any put on roles or defenses or professionalism, yet does not talk about the importance of frankness and honesty but demonstrates it into therapy. The therapist is seen by the patient as someone who tries actively to sense and enter into his feeling and experience with utmost sincerity, frankness and openness and yet respects the speed of openness and separateness of the patient (details in Chapter II).

(3) There are certain mutually agreed commitments and constraints regarding this interpersonal relationship, especially, regarding *designated place for meetings, timings and duration of appointments,* its mode of conciliation or telephonic calls in crisis situations, basis of continuation or termination of therapy, etc. (see Chapter II).

(4) Psychotherapy needs to be distinguished from the much broader methods of psychological treatments likecounseling, environmental manipulation, case-work, advice and support, suggestions, hypnosis etc. The communication by one person to another that she understands and respects and wants to help, are seen and felt by the other, as if there is someone who wants to enter into *feeling experiences* by continually trying to follow his story and actively sensing the present problems with its *historical origin.* In offering this type of help, whenever the therapist shifts her communication of *person-related* understanding to *doing something* for the welfare of the patient, then, although these may be psychotherapeutic the treatment procedures are not analytic psychotherapy. This communication by the therapist to *several people together* is possible, as in group psychotherapy, family therapy or by more than one therapist as in cojoint-couple therapy (see Chapter III) in addition to one to one relationship of individual psychotherapy.

(5) The therapist sees the patient as a person of unique assets and liabilities who is worthy of her love, labour, time and effort. He should

be provided scientific explanation of how his behaviour can best be understood. And to what extent this knowledge, at this stage, can be effectively communicated in terms of his chances of recovery with the clear understanding that the patient is the *final judge of his own feelings and experiences* as well as of the *value system*. The primary function of a therapist is to promote attitudes in her patients which are favourable to their psychological progress. There are certainly several strategies but she should manage to have the patient approach his own difficulties in the right spirit of tolerance, objectivity and the ability to change pain into power. Only an insecure person or a spiritual authority or *Guru* (super human being) can say that he knows the truth which lies in the other person's mind. Despite the human characteristic of hiding from myself my own thoughts, feelings and becoming defensive, I believe that none can ever know what I can know about myself and the same view I try to take towards my patients. The *unconditional positive regard* and *congruence* are very well documented and are researched topics in 'Client-Centered psychotherapy' founded by Rogers (1951, 1959). However, I imbibed them from my training analyst, late *Abram Kardiner,* who was analyzed by Sigmund Freud and who held in great respect the *cultural differences* to the extent of fascination for studying various cultures scientifically (see Reference). There are several other psychoanalysts who have emphasized that a useful interpretation of material is always near the *surface of consciousness* (Greenson 1967, Wolberg 1965 and several others); thus there is more than one way of accomplishing the desired results.

(6) In psychoanalytic psychotherapy, the therapist listens to the patient in a unique and complex manner with *several aims in mind*. The so-called 'listens with evenly suspended, evenly hovering, free floating attention' (Freud 1912b) or 'listening with the third ear' have the aim that the therapist can oscillate and blend this information with her free associations, empathy, intuition, introspection, problem solving thinking, theoretical knowledge etc.(Ferenczi 1928b).

Innumerable variations exist as to the use of language, minor procedures, figures of speech, timing, choice of subject matter, but the psychotherapists should be sufficiently adaptable to handle these in a way which is comfortable and *natural for a patient*. In Eastern countries epic stories, myths, fairy tales, fables and parables serve as instruments of *folk psychotherapy* and provide a theory of personality and destiny of mankind. Therefore, the Eastern psychotherapists in clinical practice often make use of such material to enable patients to *open up* further or leave behind a line of thought to derive their own conclusions from such age old wisdom (Satya Nand 1972, Peseschkian 1986). The metapsychology of psychoanalytic interpretations is often criticised for being based on Jewish culture (though this has universal application in several ways). We should make use of our own rich cultural heritage of folklore, literature, art, religion, philosophy etc., in modern psychotherapy because that is the language to which our patients

have been exposed since their infancy. The ultimate aim of psychoanalysis is to make the patient replace his complaint (in medical parlance - symptoms) *by an act of choice,* to make him fully aware of what had led him to resort to such plight and to maximize the patient's experience. Yet, he is not to be allowed to become omnipotent or grandiose, since freedom of right also involves duties to be performed, especially as in the Eastern culture the dictum is 'the greatest good is for the greatest number'*. Even when given the right to madness by some mental health workers in the West, patients are required to be treated when their insight and judgment are impaired. The Western psychotherapist enables the patient to experience himself in his environment, as acting upon each other rather than his being a passive recipient of forces within and around himself, as if the world of possibilities has become somewhat larger (Kramer 1978). In India, the famous *dialogue* between *Arjun* and *Lord Krishna* in *Bhagavad Gita,* which ends in giving *Arjun* the right of exercising his personal choice (Chap18: 63), says it all:

इति ते ज्ञानमाख्यातं गुह्याद्गुह्यतरं मया।
विमृश्यैतदशेषेण यथेच्छसि तथा कुरु।।

It means in simple translation that *after listening to all this most secret wisdom, you may do as you like.* In any psychotherapy, constant consideration must be given to the *demands of the society* in which the patient lives. There are certain standards and moral codes that will continue to exert pressure on the patient whether he elects to follow them or not. An appreciation of the norms of his group would be a sound basis upon which he decides to what extent he should follow the conventional ways of behaviour or change them.

Psychoanalytic Theory: an Inexact Science

The research evidence in carrying out modern psychotherapy in the Indian setting is yet to emerge. Studying the various theories of personality advocated by Western psychologists and checking them out in clinical practice will not help because comprehension of psychotherapy and personality are not separable (See Chapter I). This book adheres to the psychoanalytic technique of psychotherapy. Deviation from the psychoanalytic theory of personality may be due to the research evidence yet to emerge in carrying out modern psychotherapy in the Indian setting. The therapist resorts to understanding the patient's communications through verbal and non-verbal symbols and tries to construct a theory of personality on the basis of her clinical experience, the types of patients seen and effectiveness of technique found. Freud's psychoanalytic theory of personality (not the same as the psychoanalytic technique of treatment) is one of the most extensive and powerful conceptual schemes.

* To quote Mahatma Gandhi, "We have learnt to strike the mean between individual freedom and social restraint. Willing submission to social restraint for the sake of the well-being of the whole society enriches both the indicvidual and the society of which he i s member." In Mazumdar, Ammu Menon, Social welfare in India: Mahatma Gandhi's contributions, Bombay, Asia Publishing House, 1964, p.40.

Theories of personality are not limited to the science of modern psychology (Hall and Lindzey 1957). In the course of psychotherapy, instead of moulding the patient into psychoanalytic theory of personality, the *choice* of being *moulded by self-search to control his destiny* should be *left* with the patient. Even those psychotherapists who believe in structuring psychotherapy like performing an experiment, for example, behaviour therapist, also emphasize and pay special attention to 'cognitive processes' in their subjects (Chapter III).

The author is fully aware of the dangers in deviating from psychoanalytic theory of personality while practising the psychoanalytically-oriented psychotherapy. This approach may be seen as *loosely applied* to psychoanalytic therapy methods based on the *author's personal and special theoretical postulates.* It is necessary to emphasize this as Tartakoff (1956) had criticized reviewing the books using 'Psychoanalysis' in their titles. This rigid view stems from reluctance of psychoanalysts to fully expose their methods of practice to scientific enquiry. Publication of innovative modifications and deviations can clarify and be tested for establishing the scientific validity of psychoanalysis and to give impetus to the development of psychoanalytic technique of psychotherapy.

A *major objective* of writing this book was to organise the *data* gathered on psychoanalytic psychotherapy *without charging any fees in the Indian setting.* It will also initiate seriously interested readers in how to go about understanding people in distress. Also the treatment procedures for examining the 'mystique of psychoanalysis', namely, what occurs in the patient in psychoanalytic psychotherapy, for appreciating the difficulties encountered in analysis of transference and of resistance and how to make use of them in therapy.

In India, there is a *rapid social change* after closing down the large mental hospitals, especially, due to the awareness of Community Mental Health Programme. Mental patients are being treated at general hospitals like any other medical patients. There is easy availability of some psychiatric treatment at Primary Health Centres at district level. Several Integrated Rehabilitation Schemes have been launched for the welfare of the mentally handicapped and various other groups of the disabled. In some cities speciality-clinics/advanced centres have been opened to deal with the problems related to Alcohol and Drug abuse, Juvenile-delinquency, Sexual-abuse etc. Public recognition that psychiatric care and treatment cannot be imparted solely and simply by pharmacotherapy has exerted enough pressure on the psychiatric profession to develop and widen the scope of related disciplines like clinical psychology, sociology and social work.

Despite the lack of proper facilities for the training of psychotherapists so that an accredited status is given to them for practising independently, one finds a number of clinical psychologists, psychiatric social workers, apart from psychiatrists, engaged in psychoanalysis or behavior therapy practice

mostly in metropolitan cities. The present day changes in social consciousness taking place all over the world due to the rise of human rights and feminist movement will attract serious attention to psychotherapy and related issues in the contemporary Psychiatry in India.

CHAPTER I

CONSCIOUSNESS: CONCEPTS & THEORIES

1.1 Introduction

In order to be an effective psychotherapist it is necessary to work within the context of a cohesive theory of personality and overall conception of the psychotherapeutic process (Weiner 1975). Though psychoanalysis evolved gradually as Freud struggled with 'Studies on Hysteria' (1893-95) and completely treated his first patient, Elizabeth von R. (1892), with waking suggestions, abandoning 'Hypnosis' - the conventional therapeutic method of that time which he had learnt with Charcot. By 1896 Freud had already completed his essential work 'The Interpretation of Dreams' although it was not published until 1900. There is no exact date for the discovery of the procedure of 'Free association'. Probably it developed between 1892-96 and was steadily refined (Jones 1953). Jones describes a historic occasion when Freud had been pressing and questioning Elizabeth Von R., his first patient. She reproached him for interrupting the flow of her thoughts. Freud accepted his patient's suggestion and the method of *free association* took a giant step forward. The method was found equally effective as hypnosis and suggestion for widening the consciousness as it allowed the pathogenic memories, fantasies and other involuntary thoughts of the patient to enter the treatment situation. Freud's description of free association is that it is a flow of ideas "without exerting any other kind of influence". He invited his patients to lie down in a comfortable position on a sofa while he himself sat on a chair behind them outside their field of vision. He did not even ask them to close their eyes and avoided interrupting them in any way, or by using any other procedure which might be reminiscent of hypnosis. Thus, the session proceeded like a conversation between two people equally awake but in which one of them was spared every muscular exertion and any other distracting sensory impression which could have diverted his attention from his own mental activity. In order to secure those ideas and associations he asked the patient to 'let himself go' in what he says "as you would do in a

conversation in which you were rambling on quite disconnectedly and at random'' (Freud 1904). The procedure of free association became known as the 'fundamental or basic rule of psychoanalysis' (Freud 1912a).

Freud's abandoning of hypnosis while retaining some of its elements like suggestion and supportive measures (which needed to be analyzed ultimately) and their later replacement with free association led to the discovery of two other impediments in his therapy. These are said to be the foundations of psychoanalytic technique of psychotherapy, viz., *transference* and *resistance*, which are required to be taken up and resolved by another method called *interpretation*. According to Greenson (1967), ''Free association has remained the basic and unique method of communication for patients in psychoanalytic treatment. Interpretation is still the decisive and ultimate instrument of the psychoanalyst''. Probably in the hope of making conscious his patient's unconscious, the psychoanalyst recovers warded off memories and overcomes infantile amnesia and achieves the ultimate goal of psychoanalysis as propounded by Freud (1923): *where id was, there shall ego be*. This clearly indicates a relative strength of ego in relation to the superego, the id, and the external world.

1.2 Need for a Theory

Before proceeding to a systematic in depth examination of the basic concepts, the primary assumption of reciprocal relationship between theory and practice must be explained - in the context of contemporary practice of psychoanalytically oriented psychotherapy or for that matter, any other form of dynamic psychotherapy.

In principle, psychotherapy questions are not different from those asked in any other scientific enquiry trying to assess the effect of a specified experimental treatment. Planned intervention is always more productive than accidental behaviour. There is greater need now than ever before that, on the basis of current scientific knowledge and techniques a therapist formulates the course of treatment, the next move to be made in order to focus the patient's attention to bring about changes in his perceptions, feelings and behaviour. Just as every individual seeks to find an answer based on grammar of a language and on interpersonal interactions etc., the therapist should similarly be able to understand what the patient is talking about. She must know clearly what is being spoken of, what is going on 'here and now' in a therapy session in relation to the past and future orientation of the patient. Often the dead space or silences reveal more about the emotions and feelings, which have a special role in psychotherapy, than the content of verbal talk of the patient. Basic concepts and techniques of the psychotherapeutic process, within the context of a cohesive theory of personality, seem to be based on such tested hypotheses in clinical practice.

There are some solution strategies which are typical of groups and cultural areas with similar historical and socio-economic situations. For ex-

ample, if you ask of a Westerner, "How is it going?", the response may be, "You keep on living, it's got to go on, the show has to go on at any cost"; but an Easterner's response has a different aspect, "Thank God we are alive, we are happy". For some, these cultural variations are just as much objects of knowledge as the individual life styles. In clinical practice, we ask how these attitudes developed, what is their function and how the individual feels about them during day time or distorts them in his dreams.

The problem of meaning appears to be universal to the needs and aspirations of human beings. Consistent with the viewpoint that a theory of personality is needed in the practice of psychotherapy, one has to pay special attention to what happens when a therapist rigidly adheres to a particular theory. The psychotherapy research, especially on factors influencing its outcome (Feifel and Eells 1963, Strupp and Bergin 1969, Luborosky et al 1971 and others), indicates that the therapists put their technique first while the patients are more concerned with their human and personal qualities. Historically, psychoanalysis stressed the intellectual mastery of certain therapeutic techniques and assumed that suitable patients would behave accordingly, whenever those techniques were applied correctly by trained psychoanalysts.

1.3 Search for Theory in Psychology

On the other hand, the personality theories, generally in present day psychology, lack explicitness concerning the nature of the assumptions underlying them. Probably this is because of their being oriented towards after-the-fact explanation rather than towards new prediction of behaviour which promote the study of the whole, unsegmented person. When the mind is capable of a wide range of responses to both internal and external stimulation an integrative theory of personality is required. The medical history is full of examples of shedding the multi-disciplinary approach after the discovery of a specific etiology or neurobiological basis of a popular disease. Even Freud had hoped that "someday mental phenomena will be describable in terms of brain functioning which is the view currently held by most psychiatrists" (Brenner 1957).

However, when systematic interactions have been repeated by more than one therapist and in a demonstrable and explainable manner, the specific theory should lead to a systematic expansion of knowledge. It should add to the collection or observation of relevant empirical relationships not yet observed. Secondly, the theory should incorporate known empirical findings within a logically consistent and reasonably simple framework (Hall and Lindzey 1957).

1.4 Studies on Consciousness vs. Body-Mind Duality

Answers to the body-mind problems have been given by several philosophers, both in the West and in the East. In fact, the mind ceases to be a prob-

lem for those who are capable of entering into the self. Those given to spiritual *Sadhana* in the East, view mind and its problems in a different light. "For them the mind is only an instrument, there is no use quarreling with the instrument" (Yuvacharya Mahaprajna 1980).

The mind-body problem is also called 'a double language position' in which one talks either the language of observable events (physiology or behaviour) or that of the mental activities (private intention, feelings, experiences, fantasy, intuition etc.). It must not be assumed that receptivity to stimuili in the environment is a prerogative of human consciousness, though at present, several scientists are engaged in the study of consciousness, including modern psychologists.

Psychology won its independence from philosophy around the middle of 19th century, under the banner of consciousness. At that time the subject was opened to immediate observation and higher mental functions like memory, concept formation etc. (Wundt 1832-1920). The normal waking consciousness in which we can report accurately what is happening in the environment, is not the only state of awareness. The altered states of consciousness, experienced by human beings are dreaming, hypnogogic state between sleep and waking, altered states under intoxication, excessive fatigue, delirium, ecstasy, mystique or supraconsciousness. Considerable interest lies in the study of such altered states of consciousness.

Freud's studies in the nineteenth century are said to be the first scientific attempt to study consciousness. As in many scientific disciplines, the various hypotheses of psychoanalytic theory are mutually related. Some are more fundamental than the others. Two such hypotheses are the *principle of psychic-determinism* (causality) and the proposition that consciousness is an exceptional rather than regular attribute of psychic processes (three-fourths is unconsciousness). According to psychoanalytic theory, unconscious mental processes are of very great frequency and significance in both normal and pathological mental functioning.

The behaviourist - a powerful school of modern psychology, denies the facts of unconscious as well as that aspect of conscious which cannot be observed under the plea that these subject matters are not for scientific study. However, with the modern electrophysiological and biochemical methods, new scientific approaches have opened up. In the cases where these approaches are unsatisfactory, we psychologists are now ready to acknowledge that there are still unexplored interesting problem areas. From the second half of the 20th century modern psychology has not only denied the private and subjective experience but has also showed readiness for serious study (Singer 1975). Almost a century after Freud's pioneering work on unconscious, advances in research methodology have made unconscious cognition a subject matter of laboratory investigations. Erdelyi (1974) called this 'a second New look'. He made a strong case for connection between Cognitive Psychology and Psychoanalytic concept of unconscious. The

consensus on the psychoanalytically inspired hypotheses of New look - I and II suggest that a third New look is well underway (Greenwald 1992).

The existence of another level of consciousness must also be acknowledged. Though psychoanalysts seldom seem to pay attention to it, serious attention by the physicists and Yoga researchers has been given to it, the so-called *Supra-cortical consciousness* (Mukhopadhyay 1987) (Fig. 1). Mukhopadhyay holds the view that the purpose of evolution of brain is to establish the identity of Consciousness without and within Consciousness. Supra-cortical consciousness is defined as a state of human consciousness in which 'self' sees the neuraxis as an inverted tree, with its roots in the eternity and branches below the peripheral nerves. The behavioral expression of SCC is love.

Present day psychology deals with consciousness directly whenever possible and indirectly through the study of physiology. *The unconscious* accounts for apparent discontinuities in our mental life. It is assumed to be the reservoir as well as the seat of two drives - sex and aggression, which are regularly fused according to the Freudian terminology, not necessarily in equal amounts. These are the motivational forces which initiate behaviour.

1.5 Personality and Psychoanalytic Theory

Psychoanalysis, founded by Sigmund Freud (1856-1939), is the oldest scientific method of psychotherapy. It is also a theory of the development of the structure of personality and its abnormality. Psychoanalysis emphasizes the interplay of personality components known as *id, ego and super ego*. Freud was brought up under the influence of strongly deterministic and positivistic philosophy of the 19th century science. Thus he regarded organism as a complex energy system which derives its energy from the food it consumes and expands it for such various purposes as circulation, respiration etc. Freud saw no reason to assume that the energy which furnishes the power of breathing or any other physiological functions is different from the one that furnishes power of our higher cognitive functions, because the physicists were firmly insisting that energy has to be defined in terms of the work it performs. If the work consisted of psychological activity such as thinking, Freud called it *psychic energy*. According to the doctrine of the conservation of energy, energy may be transformed from one state into another but can never be lost from the total cosmic system. It can be concluded from this that psychic energy may be transformed into physiological energy and vice versa.

1.5.1 Orthodox (Classical) Theory

The point of contact or bridge between the energy of the body and that of personality is the 'id' and its instincts, which are situated in unconscious region according to the *topographical mapping* of the psychic apparatus (see Glossary). The psychoanalytic theory classifies mental operations and

States of Consciousness - the Holistic View

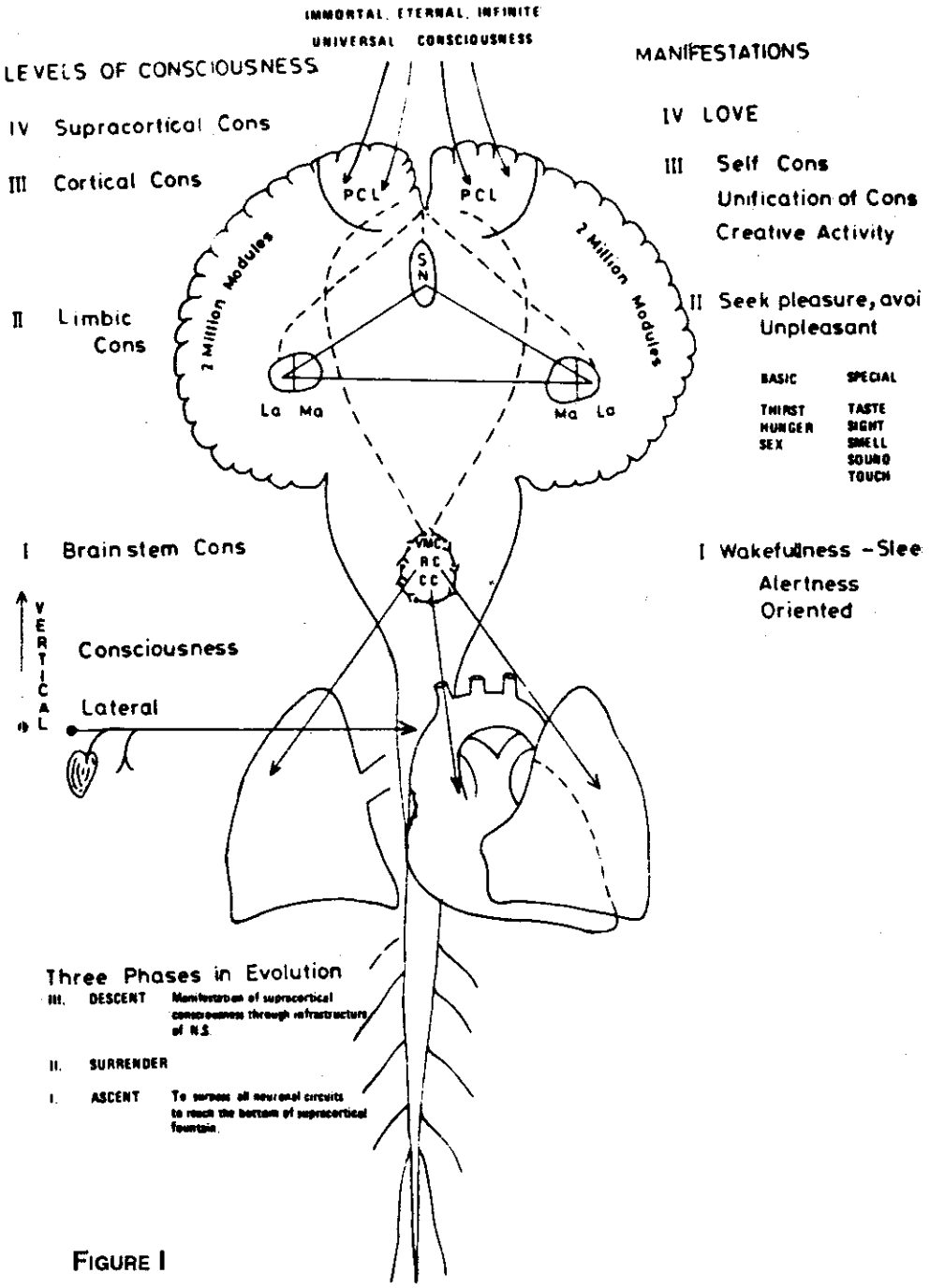

FIGURE I

Source : The Dynamic Web of Supracortical Consciouness, A.K. Mukhopadhyay, 1987

contents according to these regions, which are neither anatomical nor spatial, but are described according to their relationship to consciousness. Thus, a mental event (a wish, idea, or feeling) that occurs outside consciousness and cannot be made conscious by the effort of focusing attention, is said to occur in the deepest region of the mind, 'the unconscious'. The mental event which can be brought to conscious awareness by an act of attention is said to be 'preconcious'; which is not as 'deep' in the mind as the unconscious. Finally, there are mental events which occur in the conscious awareness and are located on the surface of the mind. In current psychoanalytic theory of the psychic apparatus the topographical approach has been supplanted by the *structural theory* of the psychic and mental apparatus, viz., id, ego and superego. The topographical system of Freud is still useful in describing the quality and degree of awareness of mental events and content.

The structural hypothesis of mental apparatus - as its name suggests, attempts to group together mental processes and contents, which are functionally related. It helps to distinguish among the various groups on the basis of functional differences. Each of these three 'structures' proposed by Freud (1923) are functionally related groups or structures and are called the id, the ego and the superego. According to Brenner (1957), ''As a way of giving ourselves a first, rough orientation, we may say that id comprises the psychic representatives of the two drives, the ego consists of those functions which have to do with the individual's relation to his environment, and the super-ego comprises the moral precepts of our minds as well as our ideal aspirations. We assume the drives are present from birth, but the same is certainly not true of interest or control of the environment on the one hand, nor of any moral sense or aspiration on the other. It is obvious, therefore, that neither the ego nor the superego develops till sometime after the birth''. Freud assumed this fact by assuming that the id comprised the entire psychic apparatus at birth, and that the ego and superego were originally parts of the id which differentiated sufficiently in the course of growth to warrant their being considered as separate functional entities.

The *drive or instinct* is a quantum of psychic energy. All the instincts taken together constitute the sum total of the psychic energy available to a personality. An instinct has four characteristic features: a source, an aim, an object and an impetus. *Source* has been defined as a bodily condition or need. The *aim* is the removal of the bodily excitation, e.g., hunger instinct abolishes the nutritional deficiency. All the activities that intervene between the appearance of the wish and its fulfillment are subsumed under the heading of *object*. The *impetus* of an instinct is its force or strength, which is determined by the intensity of the underlying need.

According to Freud's theory of instinct, the source and aims of an instinct remain constant throughout life, unless the source is changed or eliminated by physical maturation. This is in contrast to the object or means by which the person attempts to satisfy the need, which can and does vary considerably during the lifetime of the person. This variation in object choice

is possible because psychic energy is *displaceable*; it can be expanded in various ways. An instinct is also said to be *conservative*, because its aim is to conserve the equilibrium of the organism by abolishing disturbing excitations. It means that the aim of our instinct is essentially 'regressive', which Freud called *repetition compulsion*. The organism is compelled to repeat over and over again the inevitable cycle from excitation to quiescence. Freud used the analogy from physics for his psychological hypotheses by speaking of the quantum of psychic energy with which a particular object or person was invested - *Cathexis* (Freud used German word *Besetzung*) being an index of the amount of psychic energy which is directed towards or is attached to the mental representation of a person or thing. The drive and its energy are considered to be purely intrapsychic phenomena.

What are cathected are the various memories, thoughts and fantasies of the object comprising of what is called mental or *psychic representation*. The greater the cathexis, the more 'important' the object is, for example, for a small child whose mother is the source of many important instinctual gratifications. In the Freudian terminology, the child's mother is an important object of its drives, and is highly cathected with psychic energy.

In his original formulation Freud attempted to relate the psychological theory of instinct to the more fundamental, biological concepts: it is not certain whether Freud was correct or not in these speculations. He proposed that these be called life and death drives, corresponding approximately to the processes of anabolism and catabolism - the instinctual characteristics of all living matter. However, Freud is said to be the first theorist to emphasize the developmental aspects of personality, in particular, the decisive role of the first five years of life in laying down the basic character structure of a person. He arrived at this conclusion on the basis of his experiences with patients undergoing psychoanalysis since he preferred to reconstruct the past life of a person from evidence furnished by adult recollections. He formulated that personality develops due to four major sources of tension:

* physiological growth processes,
* frustration,
* conflicts, and
* threats

Learning to manage these tensions would mean personality development (see Hilgard and Bower 1975). In the course of normal development, an individual passes through a series of rather well defined stages until it reaches old age (Table I). Each new step taken entails a certain amount of frustration and anxiety. When these become too great, normal growth may be temporarily or permanently arrested - in Freudian terms, *fixated* on one of the early stages of development. A closely related defense against anxiety is *regression*, in which a person retreats to an earlier stage of development when he encounters a traumatic experience. Fixations and regressions are said to be responsible for the unevenness in personality development. However, the dynamics of personality, to a large extent, is governed by the neces-

sity for gratifying one's instinctual needs by means of transactions with objects in the external world.

Table I: Personality Development

Year	Needs	Tasks To Achieve	Basic Traumas
1 (Infancy)	Intense & urgent demands for oral satisfaction (nutrition & sucking pleasure); sensory stimulation (optic, auditory, tactile, kinesthetic); love & approval.	Feelings of security & trust. Separation of self from non-self. Coordination; ambulation. Symbolization.	Interference with nutrition (acute or chronic illness, gastro-intestinal upsets) Interference with sucking pleasure, sensory stimulation, love & approval (separation/ death/rejection by mother) Faulty weaning.
2-3 (Early Childhood)	Investigative and exploratory needs; genital manipulation. Beginning striving for independence & mastery; aggressive assertiveness.	Feelings of autonomy; incorporation of disciplines; tolerance of frustration. Social outlets for aggression. Self-confidence.	Habit & toilet training (too lax or too severe). Interference with independence & mastery (overprotection). Faulty handling of rage aggression (severe restrictions & excessive permissiveness). Interference with investigative & exploratory activities. Interference with genital manipulation. Unconscious encouragement of rebellion by parent, alternating with excessive punishment.
3-5 (Childhood)	Need for extra-familial group contacts, & for cooperative play. Keen interest in sex, genital differences & birth processes.	Sexual identification. Oedipal resolution.	Problems related to entry into nursery school/ kindergarten. Interference with interest in sexuality (masturbatory or intimidation). Excessive sexual stimulation. Seductive parent. Mother too dominant; father too passive or absent.
5-11 (Late Childhood)	Need for intellectual growth & understanding. Need for further social contacts, & for organized team play. Need to belong to a group, club or gang.	Group identification	Problems related to entry into grade school (improper school & teachers: fear of relinquishing dependency). Neighborhood stresses. Exposure to racial & religious prejudices.
11-15 (Early Adolescence)	Intense sexual feelings & interests for which a social outlet is necessary (recreational programs especially social dancing.) Need to practice skills for successful participation in groups.	Socialization of sex drives. Resolution of parental ambivalence.	Conflict between need for & defiance of parents. Conflict in relation to sexual demands & social restrictions; masturbatory conflicts. Too lax sexual environment. Poor supervision & discipline. Lack of cohesiveness in home.

Year	Needs	Tasks To Achieve	Basic Traumas
15-21 (Late Adolescence)	Gradual emancipation from parents. Need to make a vocational choice. Growing sense of responsibility. Courtship; marriage.	Resolution of dependency Assumption of heterosexual role.	Conflicts between dependence & independence. Continuing sexual conflict. Severe economic problems.
21-40 (Adulthood)	Good sexual, marital, family & work adjustment. Community participation.	Productive work role & economic independence. Marraige; parenthood. Community responsibilities. Creative self-fulfillment.	Extraordinary family stresses. Economic hardships. Natural disasters. Illness & accidents. Racial & religious discriminations.
40-65 (Middle Age)	Acceptance of a slower life pace, physically & community activities.	Mobilization of one's total resources toward achievement of personal happi- family integeration & social welfare.	Menopausal & climactric changes. Conflicts in relat ion to separation from children, unfulfilled ambitions, sexual declination & cessation of child bearing.
65 on (Old Age)	Acceptance of physical, sexual & memory recession. Need to engage in social activities, to cultivate new friends, to develop community interests & hobbies.	Continued work, interpersonal & social activities to the limit of one's physical capacities	Conflicts in relation to lonliness, death of friends & mate, increased leisure time, retirement, failing work, physical & sexual activities. Illness. Fearful anticipation of death.

Source: Modified from the handout - 'Buidling Blocks of Personality', given by Lewis Wolberg during his lecture series at The Post graduate Center for Mental Health, New York, 1971.

When the ego recognises a dangerous situation and reacts to it by producing anxiety as a signal the *pleasure principle* enters the picture. This signal anxiety is unpleasant and the more intense the anxiety the more unpleasant it is. This sets into action what Freud called the 'all powerful pleasure principle'. Its operation gives ego the necessary strength to check the emergence of whatever id impulses might be giving rise to in the dangerous situation. He has outlined a series of typical dangerous situations which may occur, in sequence, in a child's life. The first is *separation anxiety* from an important person who is the source of gratification. This is referred to as 'loss of the object' or loss of the loved object. The next typically dangerous situation for the child is the loss of love of a person in its environment on whom it must depend for gratification; in the sense that even though the person is present, the child fears loss of its love. This is called *loss of the object's love*. The next typically dangerous situation is

It seems that the secondary process is easier to understand because of its familiarity to us. It is ordinary conscious thinking as we know it from introspection, i.e., primarily verbal concern by laws of grammar and logic. On the other hand, primary process of thinking, in which memory or the idea produces a strong impression of strangeness and incomprehensiblity opposites may appear in place of one another. Mutually contradictory ideas may coexist and their representation by allusion or analogy is frequent. A part of an object may be used to stand for the whole or vice versa. In fact, verbal representation is not used as exclusively as in secondary process; visual or other sense modalities appear instead of words. A final characteristic is the loss of time perspective: past, present and future are all one in the primary process of thinking as in patients of severe mental illness: like Schizophrenia, Affective Psychosis, Delirium or Toxic or Organic diseases of the brain. But this type of thinking is said to be not wholly pathological because its dominance or exclusiveness constitutes abnormality only in adult life. The primary process of thinking has been characterized as contents of dreams as well as the thinking of children which lacks sense of time.

Fairly early in his study of dreams and neurotic symptoms, Freud (1900) found that some elements in dreams and symptoms had meaning which were relatively constant from patient to patient, quite different from their ordinarily accepted meaning and unknown to the patient himself. However, by the process of free association such 'symbolic meaning of unconscious communications' became clear, e.g., a journey or absence stood for death, money stood for faeces. Not surprisingly, Freud's discovery of such forbidden sexual and dirty symbols excited great interest and equally great opposition. However, Freudian list of such symbols is not very long. It comprises the body and its parts, especially, sexual organs, members of the immediate family, certain bodily functions and experiences like sexual intercourse, urination, defaecation, eating and few others. Generally these are subjects of curiosity to a growing child when its ego is still immature and the primary process plays a major role in its thinking. This use of symbolism is seen in dream analysis with patients.

To complete this discussion of ego differentiation attention to healthy ego functioning is required which seeks a harmonious relationship between id, superego and the external world. Ego fulfills the task of adaptation by intrapsychic changes or by modifications in the environment through activity. This accommodation requires satisfactory gratification or discharge of instinctual forces within the limitations imposed by the external world and without pathological alterations of the ego itself. Thus ego adaptation has active and passive components as well as conscious and unconscious levels. Whenever an organism seeks to fit its needs to its environment the process is called *alloplastic* and when the environment is sought to conform to its need, it is called *autoplastic* adaptation. The notion of an *experiencing self* and *observing self (observing ego)* in psychoanalytic treatment requires

different in the two sexes. In the case of a little boy it is the loss of penis (the so-called *castration anxiety*) and for the little girl the dangerous situation is some analogous genital injury. The last dangerous situation formulated by Freud is that of guilt or disapproval and punishment by the superego. According to the Freudian theory all these dangers persist, throughout life at least to some degree unconsciously, and to an excessive degree especially in neurotic patients.

Freud asserted that anxiety is the central problem of mental illness. This assertion is acceptable to most of us today, though not the three classifications of anxiety, viz., reality anxiety (between ego and reality), neurotic anxiety (between ego and id) and moral anxiety (between ego and super-ego) or feeling of guilt (Freud 1926b). The anxiety that cannot be dealt with by effective measures is said to be traumatic. It reduces the person to a state of infantile helplessness. When ego cannot cope with rational methods it has to fall back upon irrational methods, called defense mechanisms of the ego: such as identification, denial, displacement, etc. (see Glossary). In this context severe conflict between ego and id requires to be examined and also the way in which the ego differentiates from id. The modes of functioning of the psychic apparatus (called primary and secondary processes of functioning) (Freud 1911) which are of greater clinical significance, also need to be understood.

The *primary process* was so named because Freud considered it to be the origin of the way in which the psychic apparatus functioned. It was assumed that id functions in conformity with the primary process throughout life and this is seen in psychotic illness and that the ego does so during the first years of life when its organisation is immature, naturally, still very much like id. The *secondary process* develops gradually with the interaction with environment and progressively during the early years of life - characteristic of the operation of a relatively mature ego.

The modes of functioning of the psychic apparatus is another topic related to the subject of differentiation of the ego and id from one another. The primary process refers either to a certain type of thinking (characteristic for the child whose ego is still immature or primitive), the irrational type of wishful thought (dominated by emotions) or dream-work characterized by features such as condensation, displacement and extensive use of symbols or primitive, uncontrolled emotional feelings.

In contrast, are those processes which originate in and are controlled by the ego, i.e., 'tamed' or secondary processes which are predominantly logical, controlled thinking and are characterized by the use of minimal amounts of neutralized psychic energy. Secondary process also introduces the concept of delay or postponement of the immediate discharge, which is a necessary condition for logical thought, in contrast to the primary process, which strives for immediate discharge and gratification of drives (see Glossary).

distinction to be made between *ego-dystonic* (ego-alien) and *ego-syntonic* functions (see Glossary). The unacceptable mental contents are subjectively, experienced by the observing ego as foreign to itself. In these terms ego is used in its earlier meaning, not in the structural sense and has been replaced by the current concept of the 'Self'.

To summarise, the parts of psyche which deal with environment gradually develop into what we call ego. Consequently, ego is that part of psyche which is concerned with environment for the purpose of achieving a maximum of gratification or discharge for the id, viz., ego is the executor of drives. In clinical work we deal with severe conflicts between ego and id. We do not know at what stage of psychic development conflict between ego and id arises but assume that this can happen only after a substantial degree of differentiation and organisation of the ego has taken place. Let us now turn to psychoanalytic exposition of the development of personality, called *psychosexual development* in classical psychoanalysis. It was later called *psychosocial* by the post-freudians, who have taken into account the social influences interacting with physically and psychologically maturing organism from birth to death. The exponent of this view, Erikson feels that his views are consonant with the basic doctrine of psychoanalysis laid down by Freud.

According to orthodox Freudians the child passes through a regular sequence of libidinal manifestations (both sexual and aggressive) beginning in early infancy and continuing into adulthood. The early phases described by Freud under *infantile sexuality* are centered on and organised around *oral, anal* and later *phallic* zones. These libidinal manifestations consist of pleasure giving activities, predominantly sucking (later biting) in the oral phase, expulsion and retention of faeces during the anal phase and lastly manipulation (Infantile masturbation of the penis or clitoris) in the phallic phase. The child passes through these stages within a period of five to six years followed by a latency period in which the dynamics become more or less stabilised. With the advent of adolescence, the dynamics erupt again and then gradually settle down as the adolescent moves into adulthood. The final stage of maturing is called the *genital stage* (the reader may read the details of each stage of psychosexual development from any text of Psychoanalysis).

It may be emphasized that Freud assumed that every person is inherently bisexual; in the sense that each sex is attracted to members of the same sex as well as to members of the opposite sex. According to him in early childhood mother is the source of love object for both sexes. In most people homosexuality remains latent and the boy's feelings towards his father and the girl's feelings for mother are said to be ambivalent rather than univalent in character. This condition of bisexuality complicates the affectional relationship of the child with parents resulting in oedipus complex. It consists of sexual cathexis for the parent of the opposite sex and a

Fixations and regressions of both ego and 'id' produce character traits which have been called 'normal' if they do not interfere unduly with the individual's capacity for pleasure and his ability to avoid severe conflicts with his environment. Here again one must point out that there is no sharp dividing line between the normal and the abnormal. According to the psychoanalytic theorists it is only a question of degree. According to Brenner, "The distinction is purely a pragmatic one and the choice of where to make it is necessarily an arbitrary decision. For instance, we consider that formation of the super ego is a normal consequence of the severe, instinctual conflicts of the oedipal phase, yet it is certainly accurate to characterize one aspect of super-ego formation as a permanent imposition of certain inhibition or restrictions on both ego and id in order to put an end to the dangerous situation arising from the oedipal conflicts".

Brenner advocates that a clinician who is consulted by persons in distress must risk being called arbitrary and must make a division somewhere between what he considers to be normal and what he considers to be pathological and worthy of both concern and treatment.

Freud coined two terms in connection with 'symptom', viz., *primary* and *secondary gains* of illness. He considered that the primary gain of this process consisted of an abolition or diminution of fear or guilt especially due to ego weakness which threatens to permit the eruption into consciousness of full, infantile content of id impulse. Emergence of drive derivatives via the compromise formation results in 'Psychoneurotic symptoms'. Thus, ego is able to avoid some or all of the displeasure which would otherwise develop. As seen from the side of the id it is a substitute gratification for otherwise regressed wishes. However, the symptom is preferable to the emergence of these wishes in their original form.

The secondary gain is merely a special case of the ceaseless efforts of the ego to exploit the possibilities for pleasurable gratification available to it. In clinical practice we see that once the symptoms have been formed the patient does get the advantages of special attention, care and above all freedom from role obligations. However, the greater the degree of regression, the more serious is the symptomatology which results in the likelihood of the patient requiring hospitalisation. In contrast, there are personality disorders which may represent a relatively fixed and stable equilibrium within the psyche but which vary considerably in their responsiveness to treatment.

In addition to the three main pre-genital modalities of sexuality in the child, there are other manifestations of sexual drive which are seen in the psychopathology of personality disorders. These are desires to look (*voyeurism*) and the wish to exhibit (*exhibitionism*) in which the child wishes to see the genitals of others as well as to show its own. This curiosity and exhibitionism include other bodily functions as well. The patients who came for psychoanalysis to Freud in the course of therapy focused attention on 'primal scene' (recollection of fantasy of a couple, usually father and mother, engaging in sexual intercourse) and

especially its traumatic impact on subsequent development of their personality. Thus, the sequence, may become manifest at any age, reflective notably of the mistaken notion of a 'sado-masochistic' damaging or even castrating event. Another component of childhood sexuality, which the Freudians emphasize is called 'urethral eroticism', which is associated with pleasure in urination and urethra in children.

According to the classical school of psychoanalysis personality development in childhood seems to be confined to changes in the degree of interest and importance attached to the various objects and modes of gratification of the sexual drive. In their terminology we can say that the libidinal cathexis of an object of an earlier phase diminishes (e.g., nipple or breast in the oral phase) as the next phase is reached; but it persists till the full development of later phases. Earlier Freud had recognised them as dynamic force of sex drive but he later felt that the major forces were the self-preserving interest and aggressive drive. The libido can cathect (be invested) the intrapsychic representation of objects (*object libido*) or the self (*narcissism*). This means that the person obtains gratification from stimulation of his/her own body and other people are cathected only because they help to provide additional forms of body pleasure to the child. During adolescence some of this self love or narcissism becomes channeled into genuine object choices which leads to sexual attraction, socialization, group activities, vocational planning and preparation for marriage and family raising. By the end of adolescence such socialised cathexis becomes well stabilised in the form of habitual displacements, sublimations and identification. The child changes from a pleasure seeking narcissistic person to a reality oriented socialised adult (genital stage). The earlier cathexis of oral, anal and phallic stages are fused and synthesized with the genital impulses. The psychoanalytical goal of adulthood is the famous dictum of Freud 'where id was, there shall ego be' of 'to be able to love and work'. Psychoanalysts adhere to this view of the adult ideal of personality, even though they deviated from Freud's theories.

The most striking development in psychoanalytic theory since Freud's death, is the emergence of a new theory of ego called *ego psychology* (Heinz Hartmann, Kris and Loewenstein 1949). Although Freud referred to ego as the executive of the total personality the ego always remained subservient to the wishes of id and was not granted autonomy. The id and its instincts (sex and aggression) express the true purpose of the individual or the organism's life (Freud 1940). However, the new ego psychology theory not only outlines such topics as the development of reality principle in childhood, the integration or synthetic functions of the ego and its auxiliary process of perceiving, remembering, thinking, acting etc., as well as the defenses of the ego (Anna Freud's contributions). More important is the concept of *the autonomy of the ego*. It is asserted that the ego processes are operated by neutralized sexual and aggressive energies, and are independent of aims and objectives of instinctual objectives.

According to the new theory, ego defenses do not have to be pathological or negative in character; they may serve healthy purposes in the formation of personality. Hartmann believed that a defense may become independent of its origin (akin to what Allport calls functional autonomy) in combating the instincts and serve the functions of adjustment and organisation. These theorists also postulate a conflict-free sphere of the ego. This means that some processes of the ego are not in conflict with the id, the superego, or the external world. The ego processes may become incompatible with one another and when they do the individual has to discriminate and decide about the best way to solve a problem or to make adaptation. Therefore, increasing searches have been made in the non-adaptive functions of the ego, the non-defensive ways in which the ego deals with reality or with what Freud had called *reality testing*. One consequence of this emphasis on ego's cognitive processes has been to draw psychoanalysis closer to psychology. White (1963) even proposed that the ego not only has its own intrinsic energy, but there are also intrinsic ego satisfactions independent of id or instinctual gratification. The autonomous ego satisfactions are functions like exploration, manipulation and competence in performing tasks.

1.5.2 Unorthodox and Neo-Freudian Theories

No other psychological theory has been subjected to so much criticism as psychoanalysis, especially because of Freud's childhood sexuality theory. He attributed incest and perverted urges to all human beings on the basis of a few patients who came to him for psychoanalysis as well as his own self-analysis which led him to explain human behaviour in terms of sexual motivation. Though Freud was receptive to ideas advanced by his associates (notable among them were Adler, Jung, Rank and Reich) anyone who attempted to undermine the pillars of his psychoanalytic movement was no longer considered as its member. Upon the death of Freud in 1939 his followers were faced with the difficult task of deciding about the future development of psychoanalytic movement. Significant developments were made by non-Freudians like Carl. G. Jung (1875-1961) under the school of 'Analytical psychology'. This is full of symbolism and of esoteric material derived from the Eastern tradition. It found greater recognition in England under Jung's pupils (Michael Fordham, Gerhard Adler). A great deal of Jung's contributions have been quickly superceded by the study of 'ego-development', 'defense mechanism' and 'transference'. Alfred Adler's original ideas on 'Individual Psychology' had attracted followers throughout the world and got assimilated as 'universally acceptable practices' (like the Child-guidance Movement, Short-term psychotherapy, Group problems and Class-struggle, etc.). Likewise, Otto Rank the founder of 'functional-school' of Social work in the U.S.A., the lesser known psychologists Wilhelm Stekel, Sandor Frenczi, Wilhelm Reich and Theodor Reik had detached themselves from the orthodox (Munroe 1955). The psychoanalysts listed below have been given a great historical importance for providing impetus to psychoanalytic movement in the U.S.A. :

Table II: American Contributions — Post-Freudian Psychoanalysts

Area	Contributors
Psychology of women	Helene; Deutsch.
Psychosomatic disorders	Flanders Dunbar, Thomas French, Roy Grinker and others.
Ego development	Heinz Hartmann, Ernst Kris, Rudolph Loewenstein.
Emotional disturbances in childhood	O. Spurgeon English, David Levy, Gerald Pearson, Emmy Sylvester.
Family dynamics	Erich Lindemann, Nathen Ackermann.
Psychotherapy of Psychoses	Frieda Fromm Reichmann, Gustav Bychowski
Psychotherapy of Delinquents	Kurt Eissler
Cultural Anthropology	Abram Kardiner
Various clinical matters	Kenneth Appel, Greta Bibring, Phyllis Greenacre, Ives Hendrick, Robert Knight, Lawrence Kubic, Maurice Levine, Bertrand Lewin, Sandor Lorand, Jules Masserman, Karl and William Menninger, Herman Nunberg, Clara Thompson, Gregorg Zilboorg

Source: Modified from American Handbook of Psychiatery (tenth printing), Editor: Silvano Arieti, Basic Books Inc., U.S.A. Chapter 2: Recent American Psychiatric Developments (since 1939) (Mora 1959).

A decidedly more 'autonomous position' was taken by the Neo-Freudian school which is represented, essentially, by Washington school of Psychiatry and William Alanson White Institute of New York. The impact of sociologists and anthropologists such as George Mead, Edward Sapir and others had a tremendous influence on Neo-Freudians like Harry Stack Sullivan, Karen Horney, Erich-Fromm, Erik Erikson and several others. They took the basic Freudian concepts of personality (theory of instincts, oedipus complex, influence of super-ego) and added sociologically oriented psychodynamics in lieu of the biologically deterministic view of human nature. According to Mora (1959), the essential difference between the Freudians and the neo-Freudian lies in: "Man adjusted to his society - a fundamentally optimistic view - as opposed to the Freudian's pessimistic picture of man, struggling between his impulses and the strictures of the superego".

No wonder then that, Erikson (1963) proposed another way of looking at the stages of personality development. He described a progression of psychosocial stages in which the child faces a wider range of human relationships as he grows up and has specific problems to be solved at each of these stages. As with the Freudian, how well a child solves its problems at any one stage of development may determine how adequately a person will be able to cope with new problems as they arise. A description of Erikson's eight psychosocial stages of personality development are listed in various books (e.g., Hilgard and Atkinson 1953).

In conclusion, the various stages of personality development and the three structures of personality (id, ego and super ego) are not to be thought

of as manikin that operate the personality. They are mere labels for the psychological processes that obey different principles. Personality, normally functions as a whole rather than in segments. Its biological (id), psychological (ego) and social (superego) components constitute a unity.

1.5.3 Object-Relations Theory and Other Theories

According to the *object-relations theory* (which sees the individual as fundamentally object-seeking as opposed to pleasure seeking) views action, thoughts and fantasies, including symptoms as taking place within an inner *represent-ational world*, containing the self and its objects. This theory made important contribution to an understanding of personality and human behaviour. The origins of this approach can be traced to two great movements of European thought: firstly, *Enlightenment* with valuation of reason, order and stability. Secondly, *Romanticism* with its emphasis on individuality, importance of emotions and of change. According to Holmes and Lindley (1989), "Psythotherapy is perhaps closer to the romantic impulse in its valuation of individual experience and biography, in its recognition of the power of imagination, and the need to find a meaning and a purpose in life". Therefore, four main contributions relevant to clinical problems will be discussed which show decreasing proximity to the Freudian ideas.

1.5.3.1 Ego Psychology - Adaptation and Defense

As discussed earlier, Anna Freud (1937) along with American Psychologist (Heinz Hartmann) worked on structural model of Freud - in which ego is seen working towards accommodation, adaptation, compromise and dynamic equilibrium that are comparable with a common sense notion, such as, reality testing and coping mechanisms. Analysis of ego functions clarifies how a person manages to align perception with thinking and feeling to develop a particular cognitive approach. This becomes visible in behaviour and directly reflects the person's cognitive organisation. During impairment of these functions gross perceptual distortions develop which are seen in psychosis. The ego-psychologists' contribution of the defense mechanisms have become part and parcel of psychology and psychiatry these days. The later contributors have added to Anna Freud's list of defense mechanisms. Valliant (1977) had systematized the analysis of defenses dividing them into three main groups:

* immature (e.g., splitting, projection etc., which are associated with preoedipial phase)
* neurotic (e.g., repression, intellectualization etc.)
* mature (e.g., humor, sublimation etc.)

The ego-psychologists recognize that healthy development requires a balance between a nurturing, intuitive, 'feminine aspects' and a boundary settling protective 'masculine function' (see Section 1.5.3.4). Several of these concepts have found application in Britain, probably because in the true tradition of empiricism of Locke, the British use any system as long as

it works. It is reported that British psychoanalytical scene was dominated by Melanie Klein till the arrival of Sigmund Freud, Anna Freud and other Viennese refugees analysts in 1938. She wrote in a letter accusing Ernest Jones of having done much harm to psychoanalysis by inviting Freud and his daughter to this country (Grosskuth 1986). The new arrivals were shocked at Klein's influence and regarded her work as a radical break. This later led to a series of controversial discussions and formation of several independent and interdependent groups within the British psychoanalytical society such as the Freudians, the Kleinians and the Independent groups, which agreed to share and divide training procedures (King and Steiner 1990).

1.5.3.2 Kleinian Theory - Splitting and Containment

In Melanie Klein's (1882-1960) explorations of the early mechanisms of mind (which she likened to psychotic phenomenon as seen in Manic-depressives and Schizophrenics) were important contributions and these led to a pioneering movement. A number of her pupils in Britain like Bion, Rosenfeld, Segal, Steiner and other psychoanalysts like Winnicott, Little and others, who were treating psychoses with psychoanalysis in the post World War II period joined this movement. Kleinian theory explains how the envy, destructiveness and splitting (characteristics of the inner world of psychotics and patients of borderline personality disorder) is a reflection of mental life of an infant. The question is whether these were correct reflections of infant's mental life or not. The most far reaching effect of these reflections on theory and practice is her concept of *paranoid-schizoid position* in early infancy being followed, a little later, by *depressive position*. Both presuppose her acceptance of Freudian concept of ambivalence or conflict, love and hate - ultimately between the life and death instincts. According to her this ambivalence expresses itself mainly in mental acts of *splitting* and *projection*. Thus, the infant's ambivalence towards the breast (loving it when satisfied and hating it when frustrated) causes it to divide the object in two: a 'good' breast - containing projected love that is loving to the child and the 'bad' one - containing projected hate that is felt to hate him. Both become internalised making it possible for the infant to feel alternatively supported and attacked from within. Moreover, the reprojection of these inner objects on to the external world (viz., the breast for the infant) and their further reintrojection, sets up benign and vicious spirals leading to increasing sense of well being on the one hand, or an increasing sense of persecution on the other (Paranoid-Schizoid position).

Melanie Klein holds that a very different position is temporarily adopted between 3 to 6 months of age, when the infant is integrated enough to relate himself to his mother as a whole person. The infant's anxiety is centered on the survival of good objects both inside and outside himself. The child fears that its own destructiveness and greedy impulses would destroy or would have destroyed the good breast, an anxiety that may be consciously expressed in later childhood and as the fear that its mother or father or both may

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die. Thus, in Kleinian terminology depression connotes a state of sadness allied to mourning and should be distinguished from such other feelings as a sense of worthlessness and hopeless confusion that is often mixed with it. In Kleinian theory the depressive position is the main hurdle in development. Surmounting it involves the acceptance of responsibility for the damage to the inner world followed by mental acts of reparations. But if the acceptance is too painful to be borne various defenses come into operation. Of these defenses regression is common to the Paranoid-Schizoid position or a swing into manic state, in which either the extent of the inner damage or its importance is denied.

Melanie Klein developed Freud's concept of transference into *Pure transference* analysis. This involves discarding all forms of reassurance and educational pressure with both children and adults. She felt that these could only blur what should be analyzed, viz., the transference distortions of the analyst as it emerges and changes in the patient's mind. Her concept of *projective-identification* is to explain the emotional affect some patients may produce in an analyst. Kleinians believe it to be a manifestation of the most primitive means by which a baby can communicate emotions to its mother and if they are disagreeable emotions, the baby can experience relief by doing so.

It was through her interest in aggressive forms of projective-identification occuring in analysis that Melanie Klein arrived at her concept of a very early form of envy, early stages of the oedipus complex and super-ego formation. Of these, central role has been allotted to her concept of depressive position arising when the infant is sufficiently integrated both to mourn and to feel responsible for destruction of good objects in his inner world of fantasy.

The significance of these therapeutic implications is not confined to only those who belong to her line of thinking, like, Bion, Rosenfeld and Steiner. Kleinian theory has influenced psychotherapy practice, especially that of psychotics and borderline personality patients (Spillus 1988). Melanie Klein stressed more on internal objects rather than on the ego. Her Instict theory still holds a prominent position in Fairbairn's theory of Object-relations. He had absorbed the work of Melanie Klein and had worked out the full-scale revision of the psychoanalytical theory by bringing personal Objects-relations into the center of the picture. It enabled him to proceed to a radical ego-analysis. The analyst must be capable of reliably surveying all the patients projections of internal bad objects and therapeutically good objects with whom he should grow his personality and find his own true self (Guntrip 1974).

1.5.3.3 Attachment theory - security and loss

The impact of the environmental stressors prevailing in Europe in those days, like war, concentration camps etc. led Bowlby (1907-1990) and his

colleagues to carry out rigorous empirical research from the psychoanalytic perspective. The objective was to investigate role of early childhood experience in adult health and illness. This provided research evidence to support the importance of secure-object relationship for optimal personality development. Much of the orthodox psychoanalytic theory is based on retrospective and speculative constructions of the origin of abnormal adult behaviour. This is seen in the form of 'transference-phenomenon'. Instead, Bowlby started studying with specific classes of childhood traumata and traced their sequelae. His earlier studies were on depressed infants who were separated from their mothers on admission to hospital and the children raised in residential homes. These children were offered insufficient opportunities to form stable affectionate bonds with staff members who provided them a parent substitute. Bowlby's interest in ethology, systems theory and social sciences led him to use the terms of control system rather than psychic energy, and of developmental pathways rather than libidinal phase (though he himself was a trained psychoanalyst).

According to his attachment theory an individual, at any moment, faces an array of potential developmental pathways. The course he chooses is determined by the interaction of the person as he is then and the environment as it happens to be. Attachment behaviour is what a person does to obtain or maintain proximity with figures he is attached to. Anxiety signals the fear that this attachment will be broken.

Bowlby has described three types of attachments:

* *secure*,
* *anxious resistant* (person fears losing his attachment figure and clings to him/her and this person is prone to 'separation anxiety'),
* *anxious-avoident* (expectation is being rebuffed, attachment avoided and a false self developed).

The origin of healthy development is the scene and responsive attachment of the infant to explore both, his own feelings and the outside world, and forms a basis for self-confidence and curiosity in later life. Bowlby emphasized that the interplay between attachment, loss and grief continue throughout life. This continuing developmental process is a series of stages and crises points, each with their own potential for growth and breakdown (Nemiroff and Colaru 1985, Porter 1991).

The impact of bereavement after the World War II was enormous. Religion became less significant to the bereaved. Bowlby was greatly influenced by Ivan Suttie who, in his book 'Origin of Love and Hate' (Suttie 1988) took up issues of Freudian instinct theory. But one finds an integration of social psychology and psychoanalysis in Bowlby. The Hungarian school of psychoanalysis had emphasized attachment from the start and Ferenczi's pupil, Michael Baliant is said to have brought this development to the British psychoanalysis. Anna Freud's contributions to child development, especially the sequential development is supported by research evi-

dence put forth by Bowlby et al. They hypothesized that infringements of the biological mother-infantile attachment (phase I) give rise to seperation anxiety. This confirmation gave a scientific footing to child-guidance movement all over the world.

1.5.3.4 Self-Psychology

The term *Self psychology* is usually associated with the American psychoanalyst Heinz Kohut (1971). It is also related to a group of British analysts like Fairbairn, Guntrip, Baliant and Winnicott. They have asserted that human beings are relation-seeking from birth. Unlike the orthodox Freudians, who view the infant managing or failing find the discharge of instinctual impulses, the infant is seen as being born with a pristine (pure and original) unfragmented ego which becomes split and subdivided into various subselves or egos - the central ego, libidinal ego and antilibidinal ego. This fragmentation takes place as contact is made with an imperfect world necessitating intrapsychic maneuvers to cope with reality. Aggression is viewed not as an instinct but as a reaction to frustration. Frustrations are due to the fact that the infant is not being adequately loved for himself which is of crucial importance to further psychological development. Development is accompanied by increasing interest in the 'self', 'self-systems' and their operations in interpersonal relationships.

In 'libido ego' resides the wish for love and in the 'anti-libidinal ego' the experience of love which has been interpreted by the growing infant in the process of experiencing frustration, denying or punishing. These are regarded as good and bad parts of subself. These subself structures are akin to Melanie Klein's theory of mechanism of splitting of good and bad objects. The central ego is the conscious self of every day living that tries to establish good personal relationships. Depending on what the original experience was like, the antilibidinal ego (operating from the unconscious mind) has greater or lesser power to sabotage the efforts of the libidinal ego to find love during a person's life (Sutherland 1980). In other words, there is a psychic replica of the original frustrating situation within a person which ties the individual to his past and gets activated when conditions are adverse and tends to recreate the past in the present.

According to the object-relations school, the infant in the first year of life encounters two important developmental states: the *schizoid* and the *depressive*. Due to absolute infantile dependency of human child, he/she has to make some sense of the world, i.e., within the limit set by its narrow comprehension of being a self aware ego (which is more than a collection of part-objects and separate from other persons). When love is wanted and not coming forth the infant reacts in two ways. He may hate the other for not providing it and then is depressed for fear that hate will destroy the very person that he needs and loves (Guntrip 1974). One is not sure whether this fear or the guilt of destroying the loved one leads to *depressive state* of *love made angry*. Alternatively and more alarming is the *Schizoid state of love*

made hungry in which infant grows even more hungry for the total love that is not given and then begins to fear that its own love and need for love is so devouring and incorporative that it will destroy the other person. He gets into a state of aloof withdrawal in an attempt to do without external relationships. These two stages - depressive and schizoid are 'basic' or ultimate dangers; which must be escaped from in later development. Paranoid, obsessional hysterical, and phobic defenses are used to protect the child experiencing these inner tensions. This model provides a more interpersonal frame to understand anxiety.

In this context, two basic ideas in the formulation of the object-relations theory of Fairbairn and Guntrip should be kept in view. Firstly, a secure sense of self is only developed in the context of good object-relations, i.e., a satisfying personal relationship in early childhood with mother and father or/and caring persons. Secondly, this is an ideal never to be achieved with perfect consistency. The first idea led Guntrip (1974b) to emphasize the therapeutic importance of actual good relationship in therapy which Kohut (of U.S.A.) had formulated independently in his 'Self psychology' to account for narcissism (see Glossary). The building of inner esteem takes place through two major processes of internalization: ***idealization*** and ***mirroring***. Healthy narcissism or positive feelings of self-esteem are derived from good mirroring and idealization processes and experiences. Narcissistic wounds and the psychopathology of developmental arrests and deficits are caused by twisted idealization and/or mirroring experiences. Various developmental models put forth in ego-psychology like: Erikson's psycho-social, Separation-individuation process of Mahler emphasize adaptation to social environment and its role in individuation, the concept of 'ego-state' and 'ego-boundaries', as formulated from phenomenological view point by Federn (1952). Guntrip had described the various kinds of emotional boundaries between self and others, the conscious self and one's inner emotions and fantasy. These seem to be the current issues in 'Self-psychology' since their focus is on developmental arrests and deficits - which manifest themselves in psychopathology of personality disorders as well as psychoanalytic treatment during 'transference'. In the clinical setting we come across specific but different intrapsychic structures. The experience of seperation due to loss of object significant to the child, either in a real sense or as a result of the mother's failure to mitigate the anxiety, projected onto her by the child; is one of the fundamental factors in the origin of Borderline and Narcissistic personality orders. This has been well-documented in recent psychoanalytic literature (O.F. Kernberg, R.R. Grinker, J.P. Masterson).

Baker and Baker (1987) pointed out that though Kohut's ideas are important, they neglect the interactive process between parent and child. Some children, for example, are less lovable than others and burden parents and therapists with impossible standards. Winnicott (1960) of Britain had sounded a reassuring and realistic note when he wrote of 'good-enough mothering'. It is a less absolutist concept and focusses our attention to an ex-

perience which gives the child a sufficient sense of being loved and enjoyed for himself so that a sense of wholeness develops. In the analytical setting when there are intense transference reactions from the earliest stage of psychoanalytic treatment with the borderline patient, he projects idealization of omnipotence onto the therapist. But any minor frustrations are enough to create persecutory anxiety and a tendency to regard the therapist as a 'bad object'. Although, according to Aveline (1991), "Kohut over-extends this formulation; he places primary responsibilities for maintaining these good relations on the shoulders, firstly of the parents and secondly of the therapist, who fail when they do not maintain emphathetic contact". The *object-relation theory*, emphasizes the central importance of the early mother-child relationship, internalization and its role in personality development. It then moves towards identifying character patterns with the proviso that genetic inheritance substantially contributes to personality disorders.

1.5.4 Post Freudian Psychoanalytic Movement

Psychoanalysis took North America by storm in the 1920s and 1930s and despite recent redefinitions remains firmly within the mainstream of American psychiatric culture. By contrast, its acceptance within British psychiatry has been much more cautious, partly as a result of empiricism of the dominant Maudsley school and partly owing to the reluctance of psychoanalysts for fear of being assimilated or marginalised with psychiatry (Holmes 1991).

The psychoanalytic movement underwent dramatic phases in America, more specifically, the interpersonal school headed by Harry Sullivan (who said 'a person's character is his history or her history'), Karen Horney (founder of her own Institute of Psychoanalysis and also known for her popular writings on 'newer ways' of psychoanalysis), Erich Fromm (known for his writings on social philosophy based upon American democratic system) and other neo-Freudians (essentially led by Washington School of Psychiatry and William Alanson White Institute of New York), though they differed considerably from each other. The main issues involved seem to be the theory and practice of psychoanalysis, training of psychoanalysts and fresh approaches to the study of personality. This has made psychoanalysis in U.S.A. one of the dominant viewpoints in academic circles as well as, in public life.

The source of Freud's theory was clinical - the intense idiographic approach explicitly stated his views on its method. Freud always referred to Psychoanalysis as a branch of Psychology. It underwent much development in U.S.A. due to studies in Ego-psychology and advances in treatment techniques. Halls and Lindzey (1957) accurately recorded various theories of personality which were in sharp contrast to their own views. Several other American psychologists would perhaps agree with them. Halls and Lindzey held the view that the theories of personality can and should constantly

strive to conform to the positivistic logic and rigorous experimental methods developed by the physical and biological sciences. They seemed to be lenient towards the existing theories because these represent the present state of knowledge of personality research.

British psychoanalysis received more international recognition for its contributions than within the country. Probably it is due to the conservatism of academic Psychology and Psychiatry in U.K. However, their construction of object-relation theory led to newer methods of psychoanalytic treatment of severe personality disorders and psychotic states. Child-analysis flourished under the rival influences of Melanie Klein and Anna Freud and contributed to the acceptance of psychoanalytic practice in academic circles in U.K. (Pines 1991).

1.5.5 Transcultural Perspective of Personality

Each patient has his own story which needs to be told and retold as new meaning starts emerging in the consciousness of both the 'patient' and 'therapist'. This process leads to the basic issue of concept formulation. Scientific concepts, as socoiology of knowledge has revealed are embedded in geophysical as well as socio-political circumstances. Cross-cultural Psychiatry has emerged as a recognised subspeciality in response to both, clinical necessity and a variety of newer treatment approaches, in addition to the academic interest. Of the several approaches advocated by various theorists/ schools of analysis, only a few have been highlighted in this book. There is no single or uniform approach to understand the human behaviour and to bring about a change in it. There are hundreds of psychotherapeutic studies which have demonstrated that people successfully change with the help of professional treatment (Lambert et al 1986, Smith et al 1980) in reply to the criticism raised by Eysenck (1952, 1965). Even in the West there are different ways of conceptualising problems of living and conducting psychotherapy. In addition to various forms of psychoanalytic psychotherapies there are others such as: Client-centered (Rogers 1951), Existential (Boss 1963), Humanistic (Maslow 1962), Gestalt (Pearls 1883-1970, 1973), Rational-emotive (Ellis 1962), Behaviour therapy (Watson and Rayner 1920, Wolpe 1958 and several others), Cognitive (Beck et al 1979), Cognitive analytic (Ryle 1982) and so on (see Chapter III). It raises an important issue: to what extent the human nature is universal and to what extent is it a manifestation of varying cultures and societies? Like so many other critical questions and issues a simple answer cannot be put forth.

The search for a theory of personality in Indian psychology (past and present) and the technique of psychotherapy, which can be applied in our complex culture which is modern yet traditional, multi-religious yet secular, feudal in family relationships but rooted in democratic and welfare oriented political system raises several questions: What is Indian psychology? Whether one trained in the Indian set up (who can successfully treat the Western patients psychoanalytically) is equally effective with the Indian

patients? The answer lies not only in the success of Indian psychoanalysts/ psychiatrists trained abroad but also in the formulation of the therapeutic techniques. These make it possible for other professionals to repeat the procedure and get approximately similar results. It is not easy to visualize how to systematically construct the multiple interacting variables involved in the therapeutic process based upon an integrated theory of personality. These variables have been categorized as patients, 'therapists' and analytical settings. In this context, Hall and Lindzey (1957) have written very succinctly, "Our faith is that almost any theory, if it is systematically extended and coupled with extensive emperical research offers greater hope for advance than amalgamation of existing theories, some of which are poorly stated and precariously related to emperical data".

1.5.6 Personality - Ancient Indian Viewpoint

What is true for the psychoanalytic theory of personality seems also to be true of the application of psychoanalytic therapy. In this context the ancient Indian views on personality will now be discussed. Is there such a thing called 'Indian psychology' that is distinct from 'psychology in India'. Replying to this question Rama Krishna (1988) reflects, "We can hardly speak of Indian physics or American chemistry in the same way as we talk about European history or Indian Philosophy. When we speak of Indian Philosophy, we speak of philosophical ideas that grew out of the Indian milieu and became a part of its ethos. We speak of the original contributions of Indian thinkers, ideas that did not merely emanate from the minds of thinkers living in India, ideas that can be understood as peculiarly Indian, and as being an integral part of Indians' intellectual heritage". He advocates that there are three senses in which one may refer to Indian psychology:

* Psychology done in India
* Psychology of Indian people
* the Psychology that has grown out of Indian thoughts and ethos.

The term 'Personality' is older than the term 'Psychology' itself. The Indian thinkers describe the nature of person's immediate experience and in that sense, they are introspective and phenomenological in their methods. Psychological insights of our ancestors and present day seers are not born out of experiment and observation but out of intuition and insight into the metaphysical questions. These are psychological speculations on diverse disciplines like meta-physics, poetry, mathematics, medicine, logic, sexology, psychology etc. They were seldom written down by the principal author except by his/her disciples through testimony (*Aaptvachan*) in multiple languages and have prevented any single writer to give a full account of their works. However, a very useful book on this subject has been written by Ramchandra Rao (1962).

The books covering the whole spectrum of Indian psychology are very few (Swami Akhilananda 1946, Murphy and Murphy 1946, Sinha 1958,

1961, the most recent attempt by Kuppuswamy 1985). When Rama Krishna (1988) calls 'Indian Psychology as Psychology of Transcendence' - what it simply means is an ideal state of widened consciousness. According to him, "Human psychological condition is a manifestation of various forces acting on and interacting with the 'person'. The person per se is consciousness in its pure form which is knowledge in its true state, beauty in its pristine magnificence and goodness in its ultimate perfection. But in the existential situation, the person finds himself conditioned and his behaviour determined in a variety of ways. The person becomes an instrument of individualized thought, action, and passion. Knowledge is now biased, happiness - personal, and beauty - subjective. It is possible to return the person to the unconditioned state. This could happen in various stages and degrees. There are techniques that could help in the process of returning the person to the unconditioned state, *the state of transcendence*".

In Eastern psychology, even diverse systems such as Jainism, Buddhism, Hinduism, Zenism etc., centre around techniques of meditation that allow one to simply observe the stream of awareness, giving one a detached window on one's experience. Consistent with the prescribed ways of shifting mental interest from the outer world to the inner, the various schools of yoga have developed different paths to attain a common goal of liberation (*Moksha* or *Nirvana*).

According to the classical Indian text book '*Yoga Sutras*' written by *seer Patanjali* (*Yujte iti yogah*) which means yoga is a union with God, and the persons who transcend the ordinary limits of their body and mind will enter an altered state of union with God. Buddhism and Jainism do not believe in God yet both have emphasized and understood the nature of transcendence and the methods of attaining it. It requires understanding of their language of meta-physics and meta-psychology. By describing the different stages involved in the progress from the normal to the transcendal states, ancient Indian Psychology gives us one of the most interesting treatise on phenomenology of consciousness. The topographical representation through yoga (Fig. 2) is too difficult to understand and only a person who undergoes the required training will experience this fascinating state of 'transcendence'. There are four ways of attaining this state, namely, devotional (*bhakti yoga*), knowledge and intellectual (*gyan yoga*), mystical (*raj yoga*) and action (*karma yoga*).

According to this metaphysical system, aspects of primordial matter and its three properties (*guna*)*: *Satva* (the quality of truth, harmony, luminosity), *Rajas* (energy and activity) and *Tamas* (inertia, torpor and sensual pleasure seeking) are present in different propotions. It is as if one is predominating over other in manifestation of *Prakriti*, but in union with *Purusha*, which is a transcendental state, becomes free of the three Gunas and has a

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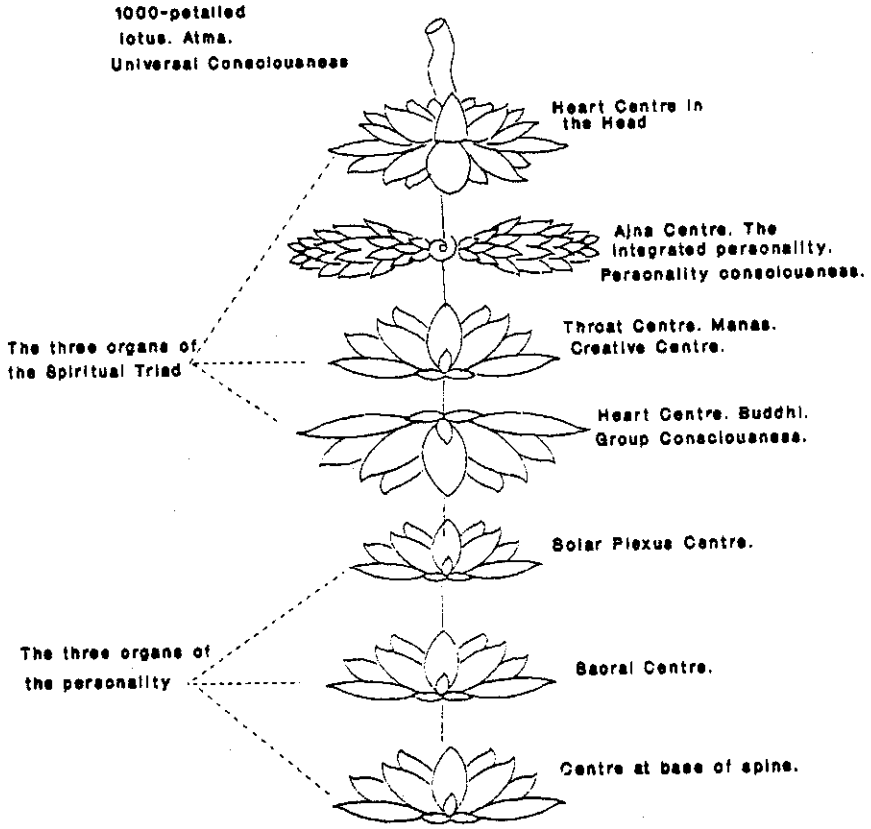
The Indian ancient system of medicine, viz., *Tridosa* theory is based upon the imbalance (*dosa*) in these three (*tri*) *gunas and differences in corresponding temperaments and personalities.*



The seven chakras in ascending plane symbolised as lotuses

FIGURE 2

The figure has been taken from Prakriti: an exhibition organised by Indira Gandhi National Centre for the Arts, New Delhi. Text source: Chakras, Energy centres of Transformation (Johri H, 1987).

very powerful effect on both, body and mind, in this *Samadhi* (concentrated state). Various yoga systems have laid down certain common adult virtues. These are concerning development of a healthy personality. The social goals of adulthood have been highlighted in the duties perscribed for the householder (*grihastha*) who enjoys a central position in the Hindu scheme of life-cycle. According to *Manusmriti* (ancient Hindu laws), "As all rivers, both great and small find resting place in the ocean, even so men of all orders find protection with the householders". The householder has several obligations: caring for parents and ancestors, *guru*, gods and all those who need love and protection. It is said that yogas are the 'psychology' of the men in Hindu world view and '*dharamshastras*' constitute the norms for the society. Sociology - an individual model of social relations, is based on a common vision of the nature of man and the world he lives in. In his life time, every individual (a householder or a recluse) has to tame his instincts and transform them into loving and caring relationships, withdraw from worldly attachments (emotional withdrawl and individuation process), prepare for death and search beyond life. The psychological portrait of the liberated Hindu *yogi* may seem mystical, but shows a marked convergence with that which psychoanalysts regard as the ideal of the healthy adult. Though over-concern with death is perjuratively called 'mystical' and its aim labeled as pathological and regressive.

However, practice of yoga is neither, merely, a control of body and mind nor is it a system of breathing in and breathing out or escape from the world. According to a modern seer, J. Krishnamurthy, (1979) "Meditation is that light in the mind which lights the way for action, without that light there is no love". Meditation can produce certain lasting changes in personality and can treat many physical, psychosomatic and mental diseases.

In order to find out whether the meditative state can be distinguished from other states of consciousness a study was carried out in the early 1960's, in the Department of Physiology, A.I.I.M.S., New Delhi. A group of workers reported electro-encephalographic correlates of this so called 'concentrated state' in which a person feels ecstasy but is oblivious to environmental stimuili (Anand et al 1961). Many such studies on E.E.G. correlates (Kasamatsu and Hirai 1966, Hirai 1974 and others) on Zen masters have come out. Hundreds of studies on psychosomatic disorders and aspects of positive mental health: like locus of self control, empathy, loss of fear of death and so on, tend to bear out that *meditation reduces negative states while increasing the positive ones.*

In most traditional systems of medicines, man is regarded as a miniature cosmos where body is composed of the five elements. The association of the elements in the parts and functions of the body were the foundation of the disciplines of Holistic medicine like Chinese medicine, *Yunani* medicine, *Ayurveda* and *Yoga*. According to *Ayurveda* the human body constitutes five elements - Ether, Air, Fire, Water and Earth. The five elements give rise to three humors - *Vat, Pitt* and *Kapha*, which govern the physical and men-

tal functions of the body. The characteristics of each humour are related to the fundamental elements from which they originate. In Ayurveda, illness is not considered to be limited in space and time and never occurs by chance. It could be due to an *accumulated period of disharmony and imbalance* in an individual over a period of time which may be beyond the span of one life time. Therapy is given at the *rational, psychological and spiritual levels.*

At the rational level, the treatment is by meditation, manipulation of diet and local application of medicines or other such methods. At the psychological level, the power of mind is used to help in the healing process through several methods such as meditation, auto-suggestion etc. At the spiritual level healing is by recitation of *Mantras*, wearing of roots and gems and auspicious activities (charity etc.). Treatment is done at all the three levels simultaneously.

In his book 'Psychotherapy East and West', Watts (1963) has recognized that 'Eastern ways of liberation' resemble Western psychotherapy and that both are concerned with changing peoples' feelings about themselves, their relationship towards others and towards the world of Nature. According to Hall and Lindzey (1957) "Western therapy, for the most part, deals with disturbed people; Eastern disciplines with normal, socially adjusted people. Even so, Watts saw that the aims of the ways of liberation were compatible with the therapeutic goals of several theories, notably Jung's Individuation, Maslow's self-actualisation, Allport's functional autonomy and Adler's Creative self-hood". Several Indian psychiatrists (Vidya Sagar, Kripal Singh, J.S. Neki and others) agree with the Western view that psychotherapy can be increasingly seen as the modern successor of religion.

As the Western psychologists and analysts with transpersonal orientation in their search of 'Peak state' or 'Unitive state' or Spirituality turn to Eastern psychology and its practitioners - *Yogi* or Zenmasters, we require to explore the modern Western sciences. They have provided a methodology for studying the basic dimensions of personality, genetic view point of personality from birth till death, *theory of psychopathology* (which makes us skillful) and the accuracy for prediction. The modern psychoanalysis is famous for giving a methodology for disciplined subjectivity (introspection) or the so-called 'trained empathy' (Roland 1988) to science of psychology.

To quote Pearson (1982), "The unity of all sciences consists alone in its methods, not in its material". Today few would subscribe to the notion that there is a single objective scientific method that will undoubtedly lead us closer to the truth. Kuhn's (1970) notions of scientific paradigm is important to remember. Scientifically, there are no easy criteria that determine the superiority of one paradigm over another. The reasons for switching them are more psychological and sociological than logical. From this perspective it is somewhat naive to assume that science is so objective that we could specify certain criteria, which define genuine science had been arrived at by truly objective observations. Our observations themselves are, to a

degree, subjective because they are carried out against the background of a culture with a certain *belief system*. As professionals in mental health we are expected to understand the normal and abnormal modes of psychological functioning, interpersonal relationship and its development in various culture and societies.

In the present day psychiatry, we do make assumptions and interact with each other with some implicit understanding of psychopathology. The advancement in psychiatric classificatory system put forth by WHO (ICD 9, 10 or in United States DSM I, II, III-R or the subsequent revisions) overemphasizes the fact that psychiatrists can perhaps identify the 'diseases' so described in terms of broader categories, sometimes unreliably (Kreitman et al 1961, Arthor and Gunderson 1966). The weekly clinical case conferences in teaching hospitals bear testimony that current day psychiatrists differ greatly in their way of diagnostic labeling despite the above stated classificatory system. In the post-independence era there is a need for developing psychology, psychiatry as well as other sciences which are in tune with our own cultural milieu. Efforts towards identifying critical variables accounting for differences in patterns of psychiatric illnesses and their treatment approaches have been focussed on psychological and social determinants (K.C. Dube, N.N. Wig, Shardamba Roy and others). However, *the progress of science depends on the richness of the underlying thoughts, the efficacy of the methods used and the passion with which they are pursued.* A few Western psychologists, such as G.W. Allport, G. Murphy and L.Murphy, urged others to pay attention to Eastern psychological thoughts. A greater number of Western thinkers will be attracted to us, provided we remember what Polayni (1966) advocated, "that passion and controversy moved by passion, must continue in science and that a comprehensive revision of our philosophy of science is needed to give due weight to this essential aspect of scientific truth".

1.5.7 Psychoanalysis in India

The Indian Psychoanalytical Society is one of the older members affiliated to the International Psychoanalytic Association since 1922. The founder and the first President of this society, G. Bose, is said to have set himself on a course of clinical exploration independently similar to Freud and corresponded with him in the year 1921 on his 'Concept of Repression' (Bose 1966). He had kept up a life long correspondence with Freud on his theory of opposite wishes. This thesis won Bose the coveted doctorate degree of Calcutta University and an academic position as a lecturer in the Department of Psychology, which meant psychoanalysis was recognised as early as the 1920s. Bose differed from Freud in the fundamental, cultural and philosophical assumptions underlying his psychoanalytical method. He questioned the evidence of castration fear among Indian patients and insisted that a wish to be a female was very often seen among his male patients. He did not mention penis envy. According to Hartnack (1990), "In Bose's view,

the conflict between the son and father is resolved not by the son succumbing to the father's authority, but, on the contrary, by the son's ability to overpower, that is, castrate him". These differences have been suggested to be due to the socio-cultural settings. When Bose formulated his ideas about the resolution of oedipus complex, the Civil Disobedience movement against the British rule was on. Probably this historical reconstruction of psychoanalysis in British India led to differences among European (B.Hill, C.D. Daly) and Indian psychoanalysts (G. Bose, D.M. Dutta, S.C. Chatterjee and others). A wide range of views on oedipus complex can be found in Indian psychoanalytic literature.*

The intensity of mother-son relationship is said to be the most interesting work put forth by Indian psychoanalysts. B.K.Ramanujam's (1984) analysis of the Indian myths and legends emphasises the difference in the flow of aggression in Indian and Western myths. According to him, "The direction of aggression shows that instead of sons desiring mothers and overcoming fathers (e.g., oedipus) ...we have fathers suppressing sons... and mothers desiring sons". Several other Indian analysts agree with him. Probably the son's fury at being seperated from his mother is not directed to his father alone. It is often seen diffused and displaced on all male authority figures. A psychosociological study of daughter-father relationships in Bengali culture by Manisha Roy (1975) adds another perspective to it: the importance of a girl's father as the 'first' man in her life, whom she has to give up when she joins her husband and his male relatives. Her own first born son is of major importance to her emotionally, as he helps her to redefine her position in her husband's alien family.

The Indian Psychoanalytic Society is currently centered at Calcutta, with a dynamic branch in Bombay and a relatively smaller number of psychoanalysts in New Delhi. B.M. Institute of Mental Health, Ahmedabad, is a psychoanalytically oriented mental health centre in India. It was founded by Sarabhai family in early 1950s (when Garder and Lois Murphy visited Ahmedabad). Since then it has attracted several eminent psychoanalysts, like: B.K. Ramanujam, S.K. Mitra and from abroad, J.D. Sutherland, J. Bowlby. With the untimely death of Kamalani Sarabhai (Director of the Institute, trained at the British Psychoanalytic Society) and later, the departure of its clinical director, Dr. B.K. Ramanujam (trained in USA), the Institute declined. According to Roland (1988), "The overwhelming orientation of the Indian Psychoanalytic Society in Calcutta is what is commonly referred to as 'classical Freudian,' with emphasis on the early topological and libido theories and the later structural theory, with relatively little mention of object-relations theory, ego psychological stages of development, or self-psychology and identity theory". In Bombay, largely through the influence of psychoanalyst, M.V. Amrith, now retired, the orientation is far more towards the work of Melanie Klein (Segal 1964) and Object-relations theory with

* See Sudhir Kakkar (1989) The Maternal Feminine in Indian Psychoanalysis. International Review of Psychoanalysis, vol. 3.

the work of Melanie Klein (Segal 1964) and Object-relations theory with considerable influence from Wilfred Bion (1977). In New Delhi, there is a strong Eriksonian cast to the writings of Sudhir Kakar (1978, 1979, 1982) and Ashis Nandy (1980a, 1980b, 1983) who have endeavoured to integrate psychoanalysis with social science work in India. This integration is missing from the work of the Indian psychoanalysts in Calcutta and Bombay (as well as that of most Western analysts); the classical Freudian and Kleinian perspectives are based on the assumption of the primacy of intra-psychic reality, and tend to ignore complex cultural, social, and historical factors as they are internalized with in the psyche. Drawing on broad Freudian theory as well as his extensive clinical experience at the B.M. Institute of Mental Health, B.K. Ramanujam (1979, 1980a, 1980b, 1981a, 1981b, 1986), has contributed by formulation of Indian psychological makeup and functioning within extended family relationships and Indian culture.

Roland, an American psychoanalyst visited the prominent psychiatric Centres of India several times. In his book 'In search of self in India and Japan' he writes, "To turn to the major theme of the Indian Identity: The attitudes toward psychoanalysis, of some major leaders of the psychiatric community are very significant. Indian psychiatrists commonly use various forms of Western therapies first introduced into India by the British: The current armamentarium of drugs, Electric Shock Treatment, psychiatric history taking and diagnosis, and certain forms of psychotherapy usually of a more supportive and directive type, when time allows. A variety of techniques and theories originating from the West are thus utilised in a non-conflictual way. Psychoanalysis, however, has been something of a *fish bone* in their throats. Some of the negative attitudes towards psychoanalysis can certainly be laid at the door steps of a common psychiatric ambivalence towards psychoanalysis. A more penetrating analysis of these psychiatrists' writing (Neki 1973, 1975, 1976a, 1976b, 1977; Pande 1968; Surya 1966; Surya and Jayaram 1964), however, brings to light fundamental conflicts and integrations of Westernizing/modernizing influences in the Indian mental health professional's identity" (Roland 1988).

On the other hand Roland felt that some of the Indian psychiatrists in the city of Bombay, "Closely associated with Westernizing/modernizing values, they tend to see Indian child rearing and familial hierarchial relationships as implicitly opposed to modernization (Bassa 1978). Such analysts relate to the Indian psyche and relationships through the lens of their more Westernized psychoanalytic framework". However wonders, "Why psychoanalysis developed so early in India and why it has not grown up there as it has for instance in America and other European countries (Britain, France etc.) as well as in Asia like in Japan" Roland (1988).

Possibly one reason is that the impact of psychoanalytic theory in Indian academic circles (ranging in teaching of psychology, sociology, anthropology, social work in universities and psychiatry and behavioural sciences in medical school at under graduate and postgraduate levels) has been confined

to reading theoretical concepts. There has been some debate on the suitability of Western psychotherapy (Kapur et al 1979).

Practical training and supervision of psychoanalytic practice observed at the Western training institutes of psychoanalysis are not provided in India, except in very few places. It has resulted in armchair speculation of psychoanalytic concepts. However, some of the senior Indian psychiatrists have taken interest in psychoanalysis, whose contributions seem to be unknown to Roland. The founder of the Department of Psychiatry and its first professor, late Satyanand* was a trained analyst and a great admirer of psychoanalysis. He wrote papers on psychoanalytic theory and researched on psychoanalytic concepts along with his students and colleagues. Others who have contributed to the progress of the psychoanalytic movement in India are: D.N. Nandi, Ex-Professor of Psychological Medicine, University of Calcutta, late S.K. Mitra, Ex-Director National Council of Educational Research and Training, New Delhi, those who have been actively engaged at B.M. Institute at Ahmedabad. In addition, there are several other practitioners of psychoanalysis in metropolitan cities of India. Yet the psychoanalytic movement is still lacking in the vigour one sees in the advanced countries and especially in the clinical practice of psychiatry. Psychiatrists often resort to their 'rich armamentarium' of drugs which is true all over the world.

By and large, psychoanalytic treatment is seen in terms of classical Freudian psychoanalysis and is confined to private practioners. Even other psychological methods of treatment like behaviour therapy, cognitive therapy, hypnosis or even yoga are not as popular as the psychotropic/antidepressant drugs in the current day allopathic practice. However, this scenario is changing. A sizeable number of patients are seeking methods of self-search and 'expansion of consciousness' because India now has the largest national group of scientists and technologists in the world. There is a need for integration and synthesis of psychoanalysis and Indian wisdom through scientific efforts to cater to the intervention needs of the Indian society under transition.

Our National Mental Health programme (1982) is aimed at integrating mental health services into the existing general health system. Provisions have been made to make inexpensive psychiatric treatment available to a large population, since mental health care is one of the eight components of our Primary Health Care which aims at 'health for all' by the year 2000 A.D. Psychiatrists and mental health planners are of the view that due to overloading of services and the traditional expectations of the patients for drug treatment thorough psychological investigations and psychotherapy cannot be

* Published books are: Objective Methods of Dream Interpretation (1947), Methods of Total Psychoanalysis (1957), Design for a Man (1965), Dynamic Psychology of Gita of Hinduism (1972). All available from Oxford Books and stationery Co., Scindhia House, New Delhi. Of the numerous research papers the salient one is: Total 'Psychoanalysis' or 'Soul-analysis'.

used to a significant extent even for patients from the better placed social strata (Dutta Ray 1962, Neki and Kapoor 1963, Varma and Ghosh 1976, Wig and Akhtar 1974). But these planners have hardly made provisions for the *training of manpower in psychological methods of treatment* even when a sizeable number of non-medical trained mental health workers are available in our country.

Views have also been expressed that *psychoanalytic psychotherapy is the least practised* form of psychotherapy in India and its vogue is on the decline even in the West. Such negative resistance to psychological methods of treatment is not confined to psychiatry alone. The resistance is present even in academic circles of psychology (such as in Calcutta University where Bose had laid down a firm foundation). This may be due to lack of supportive empirical data. According to Durga Nand Sinha (1986), who writes quoting Nandy, "Modern scientific psychology developed in the West and was 'transferred' to India and other countries of the third world as a part of the general process of transfer of knowledge and technology. As a typical offspring of Western thought, modern psychology and its applications through the different branches of applied psychology, psychiatry and psychoanalysis has found its way to all parts of the world. Like many other disciplines, it was imported as 'a ready made intellectual package in the first decade of the century'". He further writes that many researchers had used the psychoanalytic concepts, e.g., homosexual-love (Bose 1927a) and place of sex in Tantra (Mukherji 1926b) but they failed to generate a new line of thinking or a research on new theory. Reveiwing the special themes and nature of research in the early phases, Sinha concludes, "One inevitably gets the impression that they were imitatitive and stereotypical in nature, displaying little originality or freshness of approach".

The number of trained psychoanalysts in practice have been estimated as many as that of Sweden and France (Shands 1980). While highlighting the merits and demerits of psychoanalysis, Kundu (1991) writes, "Demerits include the difficulty in testing the concepts scientifically. There is very limited research report for the key concepts like repression, regression, unconsciousness etc. and for the key methods of psychoanalysis".

1.6 Critical Discussion

The projective tests like, Rorschach Ink blot and Thematic Apperception test, have demonstrated with sufficient predictive accuracy the *scientific validity* of psychoanalysis. No doubt, psychological tests and psychoanalysis, both, are Western imports. They were introduced in India because of the rapid social changes in a process of 'modernisation'. For rapid progress every developing country is bound to borrow from the developed ones. How far, as mental health workers, we *integrate and synthesize* such advances for our own devlopment and growth will make these 'techniques' suitable to the socio-cultural milieu. While borrowing the foreign innovations - tech-

nological, ideological or institutional, one should identify their effectiveness in the prevailing local dynamics/environment as well as integrating Western research. Indian culture is more open to change and has been incorporating various foreign innovations (Srinivas 1966, Rudolph and Rudolph 1967, Singer 1972, Ramanujam 1986 and several others). Newer formulations for development (when taking into account the current day social and cultural realities) have yet to be crystalized and documented by historians and sociologists.

CHAPTER II

PSYCHOTHERAPEUTIC PROCESS

2.1 Dynamic Aspects of Analytic Setting

In science, working hypotheses must always remain flexible in response to our empirical observations which strengthen, verify, weaken or disapprove the operating assumptions. In psychoanalysis one is required to delineate its application in clinical setting, largely modified by the *type of patient*, the *level* of training and experience of the therapist, the stage of therapy and the setting. In an experimental situation it is possible to control all the relevant variables except the independent one but in a clinical situation it is neither feasible nor desirable to be structured and formalized to such an extent. That is why *it is difficult to teach the techniques of therapy*, especially as a series of specific interactions between the patient and the therapist.

The reader should remember that a patient receiving this treatment is not sure of himself and wants to do something about his subjective distress and the conflicting forces which drive him in different directions. Moreover, when this treatment is provided without charging any fee, the opportunity is not likely to leave him in a quiescent state because psychotherapy is *centered around the very things that disturb a patient*.

The dynamics of psychotherapy revolve around two persons who are in contact with one another over a period of time. The two are bound to develop some kind of mutual understanding and emotional response. On one hand, the dynamics involve the patient with his unique personality configuration and the changes brought about due to disease process or psychopathology. On the other hand it is the therapist and the type of treatment opportunity she provides. These include the psychological investigation and the patient's response to the situation (rapport), according to what the forces (conscious and unconscious) within him dictate. Regardless of how formal, personal or rational this response (rapport) between the patient and the

therapist is the process is *highly dynamic*. This is true whether anything is being accomplished or not. This relationship has more than one function in therapy; it serves as the setting in which the rest of the treatment occurs.

The dynamics of therapy assume that the therapist attempts to act in such a way that the new experience will be helpful to the patient regardless of the underlying specific problem. She does so by using the attitudes and skills acquired during training (see Introduction). Most psychotherapists agree that once the therapist understands her patient's troubles, she may take up a position which is designed to be a *corrective experience* - interpersonal and emotional - in this particular instance. Though the approach varies according to the personality of the therapist, her own level of training and clinical experience of treating a variety of patients. The initial approach to establish a good rapport always gives favourable outcomes.

2.2 Broadening Scope of Psychotherapy

Originally the psychotherapeutic treatment was designed for treating 'neurotic patients'. It is *no more confined to neuroses*. This treatment should rather be provided to any one who wants self-understanding (insight) and cognizance of one's emotional life with the *zest for expanding consciousness* in order to know one's own feelings, thinking and their implication in emotional problems as well as feelings of well-being and adjustment to one's environment. There are neurotic individuals who do not seek any treatment and there are patients who seek treatment without any classifiable disease or emotional disturbance; especially trainees undergoing personal analysis. On the other extreme are maladjusted psychotics with severe disabilities and handicaps. There are also patients with a degree or type of disturbances who do not want psychotherapy. The reader should keep in mind that the *therapy works only with patients who want treatment*. This chapter describes how this individual differs from others. It also provides a better reference point for the examination of what occurs in the patient while he is being treated in psychoanalytic therapy without paying any fees. Before describing this process, let us review the western scene of psychoanalysis which has a long history of making use of this type of treatment.

In theWest heavy fee is charged for providing psychoanalytic psychotherapy and gratuitous psychotherapy is viewed as not possible. This is probably because *free psychotherapy* may elicit in patients feelings of mistrust, resentment, reluctance to discuss the *negative transference*, excessive dependency on the therapist and even feelings of guilt. This need not be so. Schwartz and Wolf (1969) observed that *Freud did not take this position*, rather Freud himself treated a Russian refugee (1919-1920) without charging any fees.

This book favours the opinion that though the practice of *free psychoanalytic psychotherapy is possible*, it is not in a position to reject previous hypotheses made in relation to money in the real and symbolic transactional

relationship between the patient and his therapist (Freud 1913a, Wolberg 1954, Kadis and Winick 1968). Since the financial sacrifice has been viewed favourable to the progress of analysis the patient must be expected to accept an arrangement whereby a heavy fee is charged by the psychoanalyst whether the patient attended or missed the specific session. This is also understandable because psychoanalysts make all of their livelihood from this profession. But in a setting where highly sophisticated medical treatment is provided free of charge (since trained professionals are paid by the government/Institutions for providing the services), the significance of money and its transaction seems to change. It is largely due to the current economic and socio-cultural setting of India (except in the private sector).

The *doctor-patient relationship* is highly complex and is compounded by a number of cultural, social, economic and personal factors which seem to have far-reaching implications. This is particularly seen when dealing with resistance, transference and counter-transference - the major issues of psychoanalytic form of psychotherapy (see Glossary). Apart from this, charging of fee in relationship to treatablity is another issue, widely discussed in psychoanalytic literature (Paolino 1981).

Money matters may become 'insurmountable' even to a trainee in India who likes to learn the theory and practice of psychoanalysis because learning opportunity of this technique is generally not available in our country. One has to make heavy investments for higher training, as in all other medical specialities. No wonder, in our country, doctors and nurses are required to make this *noble profession* flourish with *commitment* only towards their duty and are viewed to be in the *superior position* of a *Guru*, father, mother etc. When the doctors are unable to meet the patients' expectations they are disliked and ridiculed in public but they are seldom legally sued (as in the West) because of the present day socio-economic scenario as well as the legal aspects. By and large, the traditional view prevails that the physicians deserve higher status because of highly specialized skills which give them increasing power over life and death, along with ethical responsibility. In fact, this has given physicians power all over the world, throughout the history.

Now-a-days, the responsibilities of physicians have increased; especially in the field of Psychiatry. Even social, economic and political issues like population explosion, poverty, drug and alchohol abuse, national and international tensions require a *multi-disciplinary approach* by the mental health team. Thus, challenged by a widening social context and about the role of a doctor in a welfare state, the functioning of a well-motivated doctor gets blocked at times due to physical hardships faced by the patients and their families, such as:

* the long distance between the hospital and the catchment areas,
* inadequate transport facilities,
* lack of waiting rooms and other facilities for the outdoor patients and their families,

* the problems of boarding and lodging of those patients and their families who come from far off places,
* the lengthy procedures and time spent at registration counters, laboratory investigations etc.
* delay in or inadequacy of diagnostic facilities,
* improper setting of consultation rooms in order to provide privacy and relaxed communication,
* paucity of trained professionals at the intake and clinical work-up.

Dealing with these problems has now become a part of 'Hospital administration speciality'. Though these issues are beyond the control of the psychotherapist, they add to the level of satisfaction of the patient and his family. Frequent strikes by the various levels of hospital employees, delay and/or reduction of financial aid or even the therapist's own dissatisfaction with her emoluments and status etc. are related to job satisfaction. Furthermore, the reputation of the hospital in the community seems to determine the degree of *medical compliance*. The co-operation of the patient and his family is crucial to properly utilize the free services provided by the hospital.

In India, the rush of patients to the hospital for psychiatric care is increasing. Even the psychiatric patients and their relatives have a *wider choice* in mental health care system - ranging from traditional systems (*Ayurvedic, Yunani*, Homeopathy, Magic and folk healers) to Allopathy and its non-medical team members (Social workers, Behaviour therapists, Psychotherapists etc.). Our health planners and administrators are in constant search of solutions to meet the challenges posed by the rapid growth in the number of patients on the one hand and, on the other hand, are faced with lesser finances and trained manpower; these have been well-documented long back in psychiatric circle (Satyanand 1972, Vidya Sagar 1973 and others). Yet, the situation has not improved much. Probably the change has not occured in the ratio between doctor and patient; this is a little over one psychiatrist to more than one million people. In an empirical study (Gill et al 1990) on the characteristics of 425 psychiatric patients, it was found that those who dropped out of treatment were dissatisfied with their experiences at the clinic, and fifty percent of the dropouts reported improvement at home. Thus, the issues of 'medical compliance' has to be studied extensively. The health care provided in the developing countries has a greater responsibility of *educating the patient* and his family members especially where illiteracy, ignorance about prevention, lack of hygienic living conditions are urgent issues to be addressed and tackled. The Western ways of looking at the question of 'human rights' or for that matter 'consumer protection rights', rushing to legal experts for this complicated decision-making process may add a further social dimension to the already over-burdened health sector. Medical non-compliance in India as well as in advanced countries has been found to be associated with *severe mental and physical disability* (Lee and Romey 1990). Dropout Psychiatric patients are those who are generally unaffiliated, psychopathic/sociopathic personalities with high needs

for acceptance and approval from significant authority, or those who display other personality characteristics like paranoia, acting out or impulsiveness and are less motivated.

Nearly four decades of *Social Psychiatry research* (starting with Hollingshead and Redlich 1958) seems to have established a connection between social class, mental illness and willingness to come for psychotherapy. Some contradictory findings are also reported (Hagnell 1966, Dube 1983). Studies have shown that, even in free clinics patients of lower SES are less likely to be accepted for treatment and if accepted, they will be treated by less experienced staff members: therefore, they discontinue treatment. Further research indicated that, when all the patients were treated by equally trained staff (Senior resident level), the lower-class drop out rate remained the same. This has led to strengthening of the idea that psychotherapeutic practice aimed at *independence and insight* (which are the goals of psychoanalysis and some other forms of psychotherapies) is *not appropriate* for a large and important segment of the psychiatric population (Prince 1968, Neki 1973, 1977). It is important to keep in view that research in psychotherapy is of recent origin (1950). More research is required on the form of treatment, the nature of training, experience and skills required of the therapist, the types of specific problems and the conditions for intervention.

2.3 Patient's Emotional Response to Treatment

Some patients spend a lot of money and come well-motivated for psychoanalytic treatment. But when it comes to awareness of prohibited defenses on the part of the inner forces (instinctual drives), they start opposing the treatment through display of behaviours as if occassioned by some unknown forces or impulses, such as: arriving late, canceling appointments, acting out impulsively in defiance to therapist etc. In psychoanalytic forms of psychotherapy such behaviour has been viewed as *resistance* and requires to be addressed first in order to pave way for further analysis. The exact form of the resistance depends upon the kind of defenses the patient customarily employs to avert 'threat' to his ego.

Even in the West, where psychoanalysis and other forms of insight creating therapies have established themselves as a treatment system, the analysts are faced with resistances. Newer forms of therapies and innovative techniques of opening up the patients like Psychodrama, Gestalt therapy, Encounter, Sensitivity or Growth groups have come up to replace the classical model of psychoanalysis. Therefore, to practice psychoanalytic psychotherapy without charging any fee one needs *innovation* according to the complex interaction between doctor and patient as well as time and setting of the analytic situation.

The therapist should keep in mind that strong feelings, expectations and attitudes of the patient (for and against the process of insight-development) are of various origins and she is required to deal with these gradually. She

should be alert to those resistances which occur as a *direct* consequence and response to the requirements of psychoanalytic therapy, especially the part played by the dissatisfaction and satisfaction in *motivating* the patient to continue treatment. The patient's resistance to progress and his *emotional response* indicate the action to be taken (which cannot be fully explained but can only be appreciated in the actual therapeutic setting). One should be sensitive to what most comforts the patient as one goes about examining his anxiety. The patient expresses his anxiety in various forms - either by expressing the unpleasant emotional reactions of fear, hate, grief and pain or by relating the life-experiences of the past, talking of imaginary fears in response to unpleasant things or misfortune about to fall upon him *(anticipatory anxiety)*. At times the distress is not due to any real danger or threat but due to anticipatory anxiety, which is further heightened if the patient is completely left alone or feels alienated in the therapy. These types of emotional reactions are undesirable by themselves and to reduce them is one of the main objects of analytic therapy. Such anxiety accompanying activities and the types of defenses must be understood and analysed in order to mobilize patient's anxiety for working towards insight development. However, when the anxiety occuring during the process of treatment is acute and intolerable to the patient, it is bound to interfere with the therapy. Whereas the anxiety, which has been a part and parcel of the patient's illness or his characteristic mode of coping, should be mobilized as a motivating force for insight development. Directing or interpreting the patient's attention towards the areas of difficulty creates conscious resistance. Thus, in therapy this great *increase in anxiety serves as an indication to both*, the therapist and patient, to slow down or to do something else to dispel patient's discomfort. Consideration of the patient's anxiety during therapy reveals constant fluctuations, intricately related to the material being dealt with and the progress being made. The feeling of anxiety arises whenever the disturbing material repressed by the patient in the past, threatens to emerge into consciousness. This anxiety is expressed indirectly as a disguised expression of the patient's fear of the activity becoming unpleasant to him and to the therapist. It is an indication that the emotionally charged material was *originally repressed* because it was a painful experience. Repression is successful when the dormant feelings are not heavily weighted affectively and the person is free of conflicts of neurotic illness. But in therapy, the unsuccessfully repressed material is the subject matter the therapist and the patient attempt to deal with. It follows that they are repeatedly dealing with topics that the patient had tried to repress with incomplete results. Hence, his resistance is an attempt to cover up maladaptation or faulty learning of the past.

We should not assume that all the patients who come to us already know what is psychotherapy. In the hospital setting one is called upon to treat all types of patients with complaints ranging from medical, psychosomatic, psychiatric, minor adjustment problems in areas of work and education, marriage, family lives of various socio-economic groups, age, sex, mother tongue, religion etc. Initial screening of these patients about their

willingness, motivation and suitability for psychoanalytic treatment may or may not be successfully carried out by the referring psychiatrist. Therefore, the psychotherapist's first job is to establish a 'working alliance' with various types of patients.

What is a *working alliance*? It is a relatively non-neurotic, rational and realistic attitude towards the analyst (Greenson 1965a). In the author's opinion it is also based upon some logical considerations within the mind of the therapist about the referral being made. The therapist interviews the patient and concludes if 'psychoanalytic psychotherapy is worth trying'. This is in addition to her *inner feeling* whether she can get along with the patient or not. The patient can also sense this because he would have already debated mentally, while sitting in the waiting room as well as in the initial evaluation and case work, whether the doctors can understand him or not.

During the initial evaluation it is necessary for the therapist to pay proper attention to the *immediate questions in the patient's mind*, e.g., certain unresolved problems at the registration counter. The long wait for proper diagnosis is likely to heighten the anxiety of the patient. In the therapy room, he is full of uncertainity. Instead, he can resort to certain acts like smoking, nail-biting, fiddling with the keybunch etc., in order to avoid talking about personal matters. Simply putting a stop to such activities has evident disadvantages since that is likely to heighten anxiety or else the therapist will be viewed as a disciplinarian authourity. Yet in the clinical setting, the therapist is required to call the patient's attention to such activities or do something in order to reduce his anxiety. The patient will be required to work through these resistances with the therapist's helpful attitude. The patient may be helped to understand his own behaviour or wonder whether he considers such acts as maladaptive or compulsive enough to be abandoned. Similarly, there are certain patients who narrate their problems like a 'broken record' or hesitate to look at their personal problems openly and yet demand that the therapist gives some sort of magical treatment or immediate relief. They even demand treatments like ECT, psychosurgery or some strong medication to be given, so that their troubled minds may stop thinking and feeling. On the brighter side of this picture, the innate desire of such patients is to be able to deal with these tormenting thoughts which the skillful therapist should quickly probe into. Often the *upsurge* of emotionally charged material, coming to their consciousness, is so tormenting that they want to do away with it once and for all. While such patients demand more time the therapist can provide them only 45 minutes to an hour for continued empathic listening. The patients' emotional reactions due to prolonged distress, traumatic life-experiences and hardships etc. are likely to create *distance between the therapist and the patient*. Though this may or may not necessarily be called 'counter-tranference'. A trainee in psychotherapy, should fathom these issues herself and work through them in personal analysis.

The following study brings out the counter-tranference feelings in the trainee resulting in the resistance of the patient. Dr. M. (a Psychiatry resident)

consulted the therapist regarding Mrs.T. and informed her the Resident had worked out the case. In consultation with the clinical consultant the Resident arrived at two possible diagnoses, i.e., Endogenous depression with obsessive ideas or Obsessive-compulsive neurosis. The resident showed her keenness to learn how to treat this case by psychotherapy. The initial interview was conducted in the *presence of the Resident.* The patient took up this arrangement *readily.*

Mrs.T., aged 28 years, a housewife, was educated upto Matric and was a resident of Delhi. Her husband was holding an executive position. The couple had moved to Delhi from Punjab a few years earlier. Her presenting complaints were: repetitive ideas coming to mind, inability to concentrate on household work, feeling sad, crying spells and occasional sleeplessness. The history of the present illness was of nearly two years when the husband left for U.S.S.R. On the day of his departure the thought of the plane crashing down kept tormenting her. Similar unpleasant thoughts had been bothering her more frequently, interfering with her domestic work as well as her general initiative in day to day life. She was not able to get a refreshing sleep at night because such thoughts troubled her in the form of nightmares.

At the initial interview, Mrs. T. related her complaints hesitantly and confined her talk to her complaints. On direct probing she started talking of how these ideas started coming to her. She narrated an incident occuring one and a half years earlier when her husband had left for advanced training to Russia leaving her and their two children behind with his parents in Punjab. She was quite distressed by the constantly tormenting thoughts but was reluctant to confide in her in-laws due to shyness. So, she started observing expiatory fasts and prayers. However, she developed a new recurring idea that her husband had developed cancer. On further probing, it came out that she had once seen her husband wearing trousers belonging to her brother-in-law (a cancer patient). When she insisted on his changing the garment and having a bath, her husband refused arguing that it was not an infectious disease. Since then, the face of the brother-in-law and the trousers had been haunting her.

On therapist's reassuring remark that, "There is something making you restless in relating this incident." The patient kept quiet for a long time. After a pause, she said in an anxious tone, "I am afraid, lest by talking, it becomes a reality. Though, I know very well that this is just a thought. I constantly try to check such thoughts coming to my mind."

The therapist reassured her that it is extremely difficult to get rid of such ideas especially when we try very hard to suppress them. This enabled Mrs. T. to relate several other such thoughts and orthodox Hindu taboos which she knew were illogical but could not check them from tormenting her. She also told of her change of lifestyle from an unorthodox and liberal one to an orthodox Hindu lifestyle after her marriage for fear

of criticism from in-laws. Though her husband was 'Westernized', unorthodox, highly individualistic and rebelled strongly against such customs, he was never opposed by his parents because of his short temper. When the therapist made a connection of those issues creating interpersonal problems for her, Mrs. T. vehemently denied them, saying, "Each has a different temperament and one should get along with everyone. I am never criticized by any of my in-laws, we are very fond of one other."

Mrs.T.'s use of defense mechanism of 'isolation of feelings' was otherwise also noticeable especially while exploring the feelings of being seen by two therapists. Her complacent attitude and lack of psychological sophistication had generated feelings of helplessness and boredom in the therapist, more so because the therapist was assuming two roles simultaneously: those of teaching and treating, which were communicated to Dr. M. - who seemed reluctant to address herself to these counter-transference feelings.

In the second session, the patient came alone and ten minutes earlier. However, the session could not start on time as Dr. M. was late. Again the patient took a complacent attitude but the session was unproductive in terms of bringing out any relevant historical material. The therapist made direct inquiries about how Mrs.T. had been during the week. Mrs.T. reluctantly talked about her daily activities but narrated the following dream, "I am standing on the bridge of a river, the steps are alright while climbing up but still I was afraid while coming down."

During association on the dream content Mrs. T. brought out the connection of the rumour going around that the waters of river Yamuna had been poisoned by the enemies. She elaborated further that in the dream she had seen many other people standing on the bridge, including her husband - who had no difficulty in climbing down the stairs.

On probing by the therapist about her own feelings in the dream, Mrs. T. changed the topic remarking, "Oh! the dream has no connection - I often see incoherent dreams ... I saw a dream in which a woman was lighting a charcoal oven." From this point onwards the therapist didnot proceed with her association to the dream content but proceeded to explore her views on dreams.

Mrs. T. had seldom taken the initiative to express her feelings. She had non-verbally expressed her passive-aggressiveness by coming late for the appointments, canceling them, sitting idle in the waiting room, wearing the same shabby dress for the hospital or crying and keeping silent in the sessions. When the therapist pointed at her dress, Mrs. T. remarked that because of 'her unfavourable stars' she had to wear the same dress for the hospital visits. The therapist, being aware of these local beliefs, merely nodded her head. But Dr. M. asked her directly to talk about her childhood. Mrs. T. readily complied but only repeated the earlier information.

During supervision with Dr. M., the therapist brought out the significance of Mrs. T.'s first dream, which had revealed significant dynamics regarding attachment and seperation anxieties (mother-child relationship problems). Dr. M. quickly informed the therapist that she was going to discontinue attending the sessions as no significant childhood material had emerged in the sessions. Moreover, it was extremely difficult for her to keep aside 45 minutes for one patient in her busy residency program. Instead of working through the counter-transference feelings, Dr. M. preferred to put them aside.

Working through such counter-transference feelings requires looking into various strata of consciousness. It is well-known that we are conscious of the material coming in through our sense organs. The next subtle awareness comes to us from introspection and paying attention to our inner mind or the unconscious. Besides, there are several other strata of consciousness as well (Dube 1991). Though these have been described in the ancient *Vedic* literature, yet these have not been identified and studied scientifically. We pass through all these and live through them and if one attempts to focus the consciousness on a particular thought-point or object and tries to connect the two in order to put an end to the wanderings of the mind, it is feasible to examine counter-transference. This is called *Avadhana* in Yoga (akin to 'set in attention' in psychology). *Avadhana* has its object in external and internal world. When one is *emotionally stirred up*, it is important for him to pay attention to the *internal world*. This insight into the internal world draws inspiration from the mind only when we have begun to be attentive to our inner selves. In such a state, attention turns inwards, leaving the outside world to itself. This is a special state of mind which a psychoanalyst tries to provide for her patient in order to work through the problems of the 'unconscious mind'. *Insight and consciousness begin to operate* only in this state. So, the reader should examine carefully the procedure to be adopted by the psychoanalytically-oriented therapist.

2.4 Therapeutic Procedure

It is desirable for a psychotherapist to make personal contact with the waiting patient right from the reception room or at the bedside (indoor patient). Inside the therapist's room, the patient should be seated comfortably and assured of confidentiality and provided privacy by shutting the door.

The first session invariably starts with probing into complaints and exploring the reasons behind the *timing* and *urgency* of his search for treatment. This initial probing has many aims. The patient's problem unfolds itself in a spontaneous manner while giving him the opportunity to judge whether the therapist is listening with empathy, understanding his thoughts and the feelings which prompted him to seek treatment. For the therapist this exploration and free talk of the patient serve several purposes, broadly classified as follows:

1. Conducting in-depth interview for establishing *working-alliance*.
2. Enabling the patient to *communicate* the meaning behind his symptoms and discharging associated pent-up feelings, i.e., *catharsis*, in an 'emotionally corrective atmosphere'.
3. Evaluating the patient's *motivation and actual conditions* under which this dialogue is to progress.

2.4.1 In-depth Interview

The therapist should first *listen* to what the patient wants to *talk about*. She should proceed with the *speed of the patient*, holding back her curiosity about the onset of illness, progression of psychopathology etc., and not in a *systematic way* as is done in a diagnostic interview. The patient's own description of symptoms and the story of their onset and progression runs with the *law of psychic causality*. In psychoanalytic therapy it is called *psychic determinism* - a fundamental presupposition to the psychoanalytic theory of the formation of symptoms. According to Paolino (1981), "The principle of psychic determinism is that a mental event is never a random phenomenon, nothing happened by chance and every psychic event is determined by a preceding chain of mental events. As with the physical world, the mental world is incapable of random causation and incapable of discontinuity."

The author observed that the patients, who had visited various other doctors prior to coming to her for treatment, instead of talking freely, became emotionally blocked, became silent or innocently inquired 'You tell me what is wrong with me?' This is quite understandable from the patient's point of view. Once the patient becomes helpless or even hostile, he expects the doctor (in the Indian setting) to diagnose and cure the malady. When this does not happen in psychoanalytic setting and what the therapist as well as the patient, have in mind is unknown to each other, resistance is bound to occur. In such a helpless phase of dependency, the patient may praise the doctor hoping for the best medical treatment or just surrender to the medical authority. Such resistance is quite frustrating and can create an impasse when analytic psychotherapy is provided free. As therapists, we should recognize that the patient tries to make the doctor act like an 'ideal parent'; this is in fact, quite an expected role of a doctor in many countries.

Instead, the therapist, with her clinical experience as well as knowledge of psychopathology, tries to conduct the interview without asking any direct questions or interrupting the patient's flow of thought or his dead silence. More than words, the *non-verbal observations* of the therapist require to be pointed out in an interactional manner *evoking sufficient curiosity* in the patient to look into their *meaning, significance* or *historical origin*. However, the therapist should keep focusing the patient's attention on one or two *essential themes* to talk about at length rather than ramble about on several issues. The therapist can frankly *admit her limitation* of not being able to understand the patient completely in the available short time. Yet, she should

hold the position that the therapist makes a mental note of whatever he says and that her attention is totally with the patient in an atmosphere of complete *privacy and confidentiality*. In an emergency, the therapist does not leave the room without seeking the permission of the patient, as is also expected of the patient. The therapist should reassure him that, at that stage, it is not possible to be certain or sure about what the patient is trying to communicate. He should try to report whatever comes to his mind and this is a simple method, i.e., *free-association*, which will bring in clarity. In the author's experience, questions like what, when and how make things clearer and enable the patient to know that the therapist is attentive and is able to understand him better than others. *Catharsis* of pent-up feelings requires to be handled with utmost care and genuine compassion rather than with verbal reassurances or by any other expressive modes.

When resistance is due to the patient's unrealistic expectations and attitude, it should be handled with *common sense*. The approach should not give the impression that the therapist is being unduly obliging, intrusive or domineering in the socio-cultural setting of a doctor-patient relationship. For example, in the teaching hospitals, patients come to know that their case-material would be utilized for teaching/research purpose. The *informed consent* of the patient is taken on ethical grounds, which usually the patients readily give, however, some do object. *Even when assured of full confidentiality, one patient demanded that his case-file be burnt or kept under lock and key in the therapist's own custody*. On probing it was revealed that this patient had a *traumatic experience* in the hospital (documented in the case file). Hence, his mistrust was understandable although it had taken a delusional proportion. The therapist respected his demand.

A few aspects of the *rational or irrational side* of the relationship between two persons working together may influence the kind of relationship which would develop between them in therapy. In providing this setting, the therapist should note the *emotional response* people generally have towards the ideas of receiving help in personal matters. There is a stigma attached to psychiatric illnesses in our society. Even when the treatment is given in a general hospital, the fear of 'losing dignity', people's comments and ridicule is very much there. Therefore, one should not assume that those who do enter into psychotherapy are altogether free from this anxiety. Contrary to this is the feeling of joy of finally meeting someone who can understand the long-term distress and is readily available to help. Hence, the patient seems to be caught in a conflict of approach and avoidance. This *ambivalent attitude* towards the therapist seems to be quite different in the Eastern set-up. In the West one comes across patients who openly talk of their psychotherapist (shrink), whereas the patients visiting us in the Indian setting like to be highly secretive. This relationship may vary from patient to patient and from therapist to therapist in various settings. This ambivalence seems to be largely determined by the *society's attitudes* towards mental illness. Thus the therapists can vary in their initial approach to therapeutic relation-

ships - in the degree of neutrality to support, emotional intensity, to lack of responsiveness, to personal warmth and openness like that of a friend. These relationships may get *altered* many times throughout the course of long-term therapy. Yet, during evaluation, the therapist should keep up *neutrality* to enable the patient to verbalise his thoughts and feelings rather than act them out.

Evaluation of a case for analytical psychotherapy may not always require 3 to 5 sessions. It depends on the availability of time and the nature of clinical emergency for which the therapist's consultation has been sought. It is not possible in cases of suicidal attempts or emotional crises of students nearing examination period. In such cases, it is more important to elicit the present history (symptoms, current life situation, stress and strain), the coping style and defense mechanisms, the strength and weakness of *ego functioning* and *the motivation* for long or short term psychotherapy. The *environmental considerations* of whether the patient resides near the hospital or is admitted, working/studying in the same city, or whether he can avail of leave for long term treatment etc., may determine the possibility of therapeutic contact over a long period of time. Discussing these issues and arriving at mutually convenient *arrangements* brings out resistance in the patient. This must first be dealt with *commonsense then interpreted in intrapsychic or unconscious psychodynamics*. In fact, while establishing a working-alliance, the resistance-analysis with psychologically unsophisticated, dependent, semiliterate, illiterate or patients of severe mental handicaps or ego-defects requires some *innovations*.

It is said that a therapist, who has a strong interest in her patient, can *influence* him to talk freely because one talks more openly to an interested listener. But, in clinical practice, self-disclosure (being related to trust and ego-strength) has several *sociological and psychological variables*. Trust implies a general orientation of basic faith in people, their reliability and predictability of external world (Erikson 1963). Ego-strength is usually inferred from psychological processes of mastery, competence and satisfaction in dealing with everyday problems of living. Research evidence supports the premise that subjects scoring high on trust and ego strength disclosed significantly more than those scoring low, but these results are best understood within the *framework of communication skills* necessary for the self-disclosing activity (Kumar and Didwania 1976, Dube 1981). For example, a paranoid patient, on the surface, is a hard nut to crack because of the high mistrust due to delusion. Similarly, a verbally efficient, productive and obesessive-compulsive patient talks like a broken record without ever showing his hidden feelings*.

In analytic setting, one is also required to *imagine* what the patient has experienced and is experiencing now. This is possible, if one listens patiently and with empathy, making mental notes of the verbal and nonverbal cues and *builds up their meaning*, especially with regard to the purpose the

* For communication styles of various psychiatric patients read the text books of Psychiatry.

symptoms serve. This is a clinical practice which needs a lot of *supervision* in psychoanalytic psychotherapy. Several hours of lively discussion with the supervisor may add a further dimension to the psychoanalytic process - *the supervisory transference*. Greenson (1967) suggested a few basic *guidelines* to accomplish the three aims advocated by Freud. While listening to a patient the psychoanalyst has to -

* translate the statements of the patient into their unconscious antecedents. The patient's thoughts, fantasies, feelings, behaviour and impulses have to be traced to their unconscious origins,

* the unconscious elements must be synthesized into meaningful insights. Fragments of past and present history, conscious and unconscious, must be interconnected to give a sense of continuity and coherence in terms of the patient's life, and

* the insight so obtained must be communicated to the patient. As one listens, one must ascertain which uncovered material may be constructively utilized by the patient.

While listening with 'evenly suspended, evenly hovering, free floating attention' it is not possible to make detailed notes of what the patient is saying. Therefore, during training one is required to either *tape-record or make a detailed process recording*. But in clinical practice one does not make a conscious attempt to remember everything that the patient has talked about. One only *remembers the significant data* and can make notes after the patient leaves the room rather than getting disturbed or distracted during the session while making detailed notes. One has listened with focused attention without getting stirred-up by the transference reaction of the patient. It is said that non-selective, non-directed attention tends to rule out the *analyst's own special bias* and allows her to follow the patient's lead. The analyst can oscillate and blend this information with free association, empathy, intuition, introspection, problem-solving, thinking, theoretical knowledge etc. (Ferenzi 1928b, Sharpe 1930). All activities *interfering* with the analyst's capability to oscillate between understanding and empathizing are to be avoided during the therapeutic hour: these activities include scientific pursuits, teaching or administrative work and other role-obligations of a therapist. Listening to gain insight and understanding with compassion, patience and empathy is essentially therapeutic for the patient and not just for our theoretical understanding.

Some Indian psychiatrists have advocated that patients act towards the therapist as a family elder or *a Guru*. They expect advice rather than self-exploration. Free association was impossible in certain Indian cultures, because personal self-expression is restrained particularly verbal (out of deference). The classical neutral psychoanalytic position, 'holding a mirror position of psychoanalyst' or reliance greatly on 'verbal teaching of psychoanalytic concepts' (via interpretation) rather than using relationships is far too distant and uninvolved (Dhairyam 1961, Pande 1968, Neki 1976b). On the other hand, some psychoanalysts are of the view that Indian pa-

tients with overt etiquette of deference, loyalty and subordination to authority are able to talk easily with childlike simplicity about their very 'private self' and their problems with authourity. This is evident in cases where a patient feels a greater need for empathetic relationship and wants the therapist to fulfill those roles and responsibilities not carried out by the various members of his family or his friends (Ramanujan 1980a, 1980b and Roland 1988). The author feels that this viewpoint should be given greater attention in analytic psychotherapy.

In this context, one should understand that the patients are *mirroring the problems generated by rapid social changes* in a developing society. The patient's symptoms may be a reaction to the stresses and strains arising from the collapse of the traditional support-systems of family relationships, caste, kinship, religion, etc. A skilful therapist's familiarity with traditional patterns of a culture and the emerging needs for change enable her to adapt the psychoanalytic techniques. For probing into the areas of intrapsychic, interpersonal as well as impersonal factors (environmental stresses and strains) are required in the study of psychopathology. But the *essence* of psychoanalytic thrapy lies in successfully working-through of the past internalized 'object relationships' (parents or any other significant care-taking member) with concomitant ego-defenses in the patient's psyche (through re-experiencing in transference relationships with the therapist) and resolution of these defects and repairing in the psychic structure.

The reader must have noticed by now that the patient, the analyst and the analytic setting contribute to the formation of this type of working-alliance. The subjective distress and possibility of help from the therapist impels the patient to agree upon rigors of psychoanalytic therapy. His ability to form a relatively rational, de-sexualised and de-aggressified relationship with the analyst stems from his having such *neutralized relationships* earlier in life. His present ego-functioning plays a crucial role since the capacity to establish multiple relationships with the analyst is possible only with *resilient ego*. According to Freud, "The analyst contributes to the working-alliance by his consistent emphasis on understanding and insight by his continual analysis of the resistance and his compassionate, empathic straightforward and non-judgmental attitudes" (Freud 1912a). Thus, the *therapist's style* and the *setting* of the analytic atmosphere are important means of motivating a patient to come for evaluation even when he is not certain about its effectiveness.

The uncertainty and the lack of immediate need-gratification produce certain feelings, drives, attitudes, fantasies or defenses towards the analyst which are not beneficial to the patient. Yet he cannot help doing so as they are *repetitions of reactions* originating in his early childhood. These get unconsciously displaced on to the analyst. Similarly, the feelings of inner satisfaction and joy also get displaced. Hence, the phenomenon of 'transference':

(1) is a variety of early childhood object-relationships,

(2) it is an unconscious process which comes into awareness by the defense mechanism of displacement while interacting with the analyst, and

(3) it is a regressive mode of adaptation since it is a repetition-compulsion (instinctual derivatives of life and death).

The reader should note that psychoanalytic setting per se does not create transference reaction; it merely makes the patient *aware by facilitating its development*. Such severe maladaptive ways of the patient relating to the treating doctor may reach the level of delusion. It is *debatable* whether such ways can be called transference-reactions or not (Freud 1915b). They can certainly be viewed as 'transference psychotic reactions' since the psychotics are unable to differentiate between self and the object world (lack of reality testing) whereas the neurotics can. Transference has been *restricted* to neurotic reactions in the analytic setting, although in clinical situations, at times one sees both, the neurotic and the psychotic patients, interacting rationally as well as irrationally. The *psychotic* patients require a *direct* interpretation of transference phenomena while the *neurotics* an *insightful introspection*.

The psychoanalytic therapist quickly recognises that a patient 'acts out' (see Glossary) to avoid the psychic pain in dealing with intrapsychic conflicts. Instead of remembering the forgotten memories or bringing them into consciousness the patient engages in destructive denial and maladaptive regression. This type of behaviour is called 'acting out' in transference. Some patients like the psychopaths tend to *externalize* their transference reactions in a defiant way, without any awareness, even towards the therapist.

The process of *transference* is said to be *universal* in the sense that it plays an important part in all types of *interpersonal distortions* and is not confined only to the therapeutic setting. However, in analytic therapy 'acting in' is preferred to 'acting out' in transference since it is acknowledged that a certain amount of acting out (any behavior in or out of transference) occurs to some degree in every patient. It is quite difficult to *isolate* verbal from nonverbal behaviour within the treatment. Certain amount of 'acting in' in the therapy is necessary for the patient's verbal acceptance, understanding and insight. As the therapy becomes more *intense*, there is a progressive urge to satisfy the prohibited sexual and aggressive impulses - with immediate need-gratification, which is not possible in the therapeutic situation. Freud (1914c) noted long back, that repeating earlier patterns to resist remembering and mentally re-experiencing painful forgotten moments (of abandonment, intense loneliness and murderous rage) leads to regressive *transference neurosis* or even to *transference psychosis* depending upon the patient's ego-strength to tolerate the intrapsychic tension. The 'clinical timing' as well as 'here and now' basis of understanding the patient's emotional reactions enables the therapist to intervene and explore the unconscious. However, repressed *upsurge* makes some patients in transference-

psychosis resort to defense mechanisms such as projection, psychotic denial or distortion of reality. This could make the patient *unsuitable* for further analytical psychotherapy and may require *supportive therapy with medication*. One parameter by which we should assess the capacity of the patient to regress yet grow, is to evaluate his ability to employ *mature defense mechanisms* (see Glossary).

It is said that "the greatest advances in psychoanalytic technique were derived from Freud's (1905c) major discoveries about the *two-fold power of transference*, it is an instrument of irreplaceable value, and it is the source of the greatest dangers" (Greenson 1967). Transference reactions offer the analyst an invaluable opportunity to explore the inaccessible past and the unconscious. It also stirs up resistances which become the most serious obstacles to analytic work. It is said that 'transference reactions' occur in all patients undergoing psychotherapy but psychoanalysis is distinguished from all other therapies by the way it *promotes the development* of the transference reactions and how it attempts to analyze 'transference phenomena', systematically.

Transference has been explained by giving clinical examples given in a later section of this Chapter but one should not get the impression that transference occurs only in psychoanalytic therapy. All human relations contain a mixture of realistic and transference reactions (Fenichel 1941). They include *intra and extra analytic* as well as *positive* and *negative* transference. In most psychiatric literature the term transference in treatment setting of psychoanalysis and its other forms, refers to intra analytic transference. Extra analytic transference covers a wide range of circumstances including its occurrence in various forms of psychotherapy as well as in school, job situation, home and social interaction at large. Positive transference refers to analytic situation where predominantly friendly, affectionate and/or intense sexual wishes and fantasies are felt towards the analyst. Negative transference refers to the situation where predominantly aggression, hostility, mistrust or even sadistic wishes are experienced towards the analyst. One of the reasons for the relative *anonymity of the analyst* in the classical psychoanalysis, is that a lack of such information about the therapist's charachter and personal life *facilitates transference* of the patient's revived early images (of object-relationships) on the therapist. It also lessens the distortion of fantasies by present perception. Here, a *distinction* should be made in the situation when the therapist is available to the patient as a *real person*. In such a setting, transference should be carefully differentiated from the actual behaviour since the therapist is physically interacting. The attitude of the analyst may cause reactions in the patient. They cannot be considered as part of the transference reactions. Moreover, it should be investigated whether it is counter-transference or not. At this stage, the therapist's statements (practically in any form) are likely to be challenged later or they may create emotional reactions in the patient, which cannot be worked through at the initial stage. It should be handled with an attitude that the patient is to con-

tinue searching into his maladaptive behaviour which would be abandoned with the development of his insight and judgment.

Transference should be carefully differentiated from the *therapeutic-alliance* in which the doctor and the patient agree with and understand each other's work. It involves for therapeutic purposes, *a split in the patient's ego* into a reasonable, observing and *analyzing ego* and an experiencing, subjective and irrational, *observing ego* - cooperating with the analyst. A strong observing-ego of the patient, therefore, is *essential* for continuation of analysis during a period of strong *negative transference*. Most psychoanalytic therapists would agree that some commonly observed *sources of resistances are, in fact, issues of transference*. At times, the fear of the therapist due to transference may aggravate or alleviate the patient's emotional distress. The patient feels symptomatically better in opposition to *persisting masochism* (aggression and sadistic fantasies turning to self in prolonged sickness). Or, the patient's self-destructive impulses are aggravated which lead to suicidal rumination/attempt. This fear may be based on the *unconscious belief* that there is no real alternative to the current adaptation in life and therapy will only deprive the patient of this tilted balance in personality, which he had achieved after a long struggle and is the only means of psychological survival. Many psychotherapists in the West have advocated that patients be given the *right of madness*. However, this type of resistance may be due to unconscious forces. The empathic therapist is able to perceive the patient's thoughts and feelings and recognizes their significance not only for what the patient is experiencing at that moment but also for what may lie outside his conscious awareness. This *empathy* would mean "the ability to put oneself in another person's shoes" and to comprehend the patient's needs with an understanding of the opposing forces. The emphasis here is on the therapist's own responsivness and the *mental health model* one holds for *life's adversities*. A direct emotional response to what the patient is talking frequently requires not only handling such issues as resistance due to unconscious or conscious forces (primary and secondary resistances: Freud 1920, 1937, Eissler 1953) but also handling them with *human sensitivity*.

This type of resistance is due to unconscious forces. The clinical manifestations of the therapeutic-alliance are the patient's willingness to carry out the given instructions, mainly to report whatever comes to his mind (thoughts, feelings and emotional reactions) in a free floating manner. The patient's ability to work through regressive and painful problems with insight, (brought out via free association, transference reaction and resistances) are utilized for further development of insight and reconstruction of personality. The analyst's probing questions, clarifications, interpretations, suggestions based on the factual material available on the surface of patient's consciousness and, at times, even the confrontations between the two require a reliable therapeutic-alliance with the analyst. This process not only brings out the warded off or inaccessible material but can also *endanger* the therapeutic-alliance if the patient is unable to understand and accept it.

The factors which lead the patients to *transference resistance* in gratuitous therapy have to be looked ino because financial sacrifices are viewed as unfavourable to the progress of analysis by the Western psychoanalysts. However, the observations of the present author while adopting the following procedures in psychoanalytically oriented psychotherapy without charging a fee do indicate that financial sacrifices are not a must in successful resolution of resistance in the long psychotherapeutic process. Patients were treated after proper psychological evaluation as well as after obtaining a written consent from them and/or their families. The course of therapy as such depended upon:

- The patient's willingness and ability to continue psychotherapy for a long period (more than two years) or short term (three to six months) without breaking *two appointments consecutively*.

- Permission for *re-entry* into therapy depending upon the *therapist's open hour* for new cases.

- Referrals of psychotherapy based upon *psychodynamic* considerations as well as on the *judgment* of the clinicians regarding the *choice* rather than the patient's gender, SES, diagnostic category or the therapist's previous record of success with a particular diagnostic group.

- *Minimal psychiatric* intervention after the patient's referral for psychoanalytic therapy. Yet, in case a patient needed adjuvant drug therapy, he could seek the psychiatrist's help or in case of emergency, the *therapist herself sought* consultation from the clinicians for *psychiatric intervention*.

- Consent taken for the use of case-material for teaching/research purposes.

- T*ermination* of psychotherapy planned in consultation with a consultant Psychiatrist (usually the one who had initially referred the case). It depended upon if and when the insight could bring about demonstrable changes in terms of:

  a) modifying or preventing symptoms,

  b) infantile needs and defense operations, and

  c) adaptive personality changes replaced the emotionally distressing symptoms and behavior patterns of the patient after treatment. A subjective improvement noticeable as well as a better actualization of the patient's potential - in terms of work, interpersonal relationships and zest for life.

While assessing the patient (in the initial exploratory sessions) the nature of resistance and its source ought to be understood and worked through to a certain degree of *smoothness in doctor-patient relationship before formulating the therapeutic-alliance* with the patient in terms of mutually agreed upon arrangements mentioned above. As emphasized earlier, resistance is the defense reaction of inner forces. A patient opposes the treatment

of any kind of psychotherapy inspite of consciously being eager to cooperate and willing to do anything the therapist asks him to do as if he wants to get well at any cost. This clinical observation made by several psychoanalysts is of a great significance in understanding conscious and unconscious motivations because the severity of the symptoms and their subjective distress, with which a patient presents to us, are generally *unreliable guides*.

As a rule, when a patient is resisting one should *call attention* to it and prepare the patient to begin the exploration of the reason behind his inability to bring out any further information. This is carried out through verbal and non-verbal technique. The reader should note that resistance could be due to lack of proper scientific knowledge or even *misinformation*. The author had observed that some patients came willingly for psychotherapeutic evaluation on the advice of their treating physician. They came inspite of being convinced that they were suffering from some organic disease which had not been thoroughly investigated. To explore this compliance, the therapist should frankly ask the patient his opinions and *preconceived notions* regarding his symptoms and expectations from the line of treatment before establishing therapeutic-alliance. This may require *educating the patient* regarding the etiology of functional diseases and the nature of psychotherapeutic treatment.

When a professionally competent psychotherapist decides to take on a patient for therapy (having resolved the initial resistance), she should follow it up by bringing down the level of anxiety and depression and work towards relief in somatic complaints. This progress should be verifiable by the *patient's active involvement* in the therapeutic process-searching of the sources of his odd experiences, feelings, thoughts, fantasies, dreams or any other material which comes to his conscious awareness. The following technique for modification may be adopted:

1. Passivity in therapeutic interaction to be superseded by activity in handling issues of resistances and transference reactions.

2. Free association to be abandoned as a 'fundamental rule'. Interviews to be either semi-structured and focused or conducted at a pace *(speed)* set by *the patient* in a free floating style of focusing attention.

3. The 'Couch-position', not imperative, may be used only for *relaxing* and enabling the patient to relate without feeling awkward while talking of the censored topics.

4. Positive elements of good doctor-patient relationship to be encouraged like rapport - to develop further into transference reactions.

5. Both *conscious and unconscious material* to be discussed in therapeutic sessions. The patient to report day-residual psychosocial stresses as well as somatic complaints, sleep patterns, dreams, fantasies etc. and make his own mental notes or keep a diary for bringing such material to the therapist.

6. *Details* regarding frequency of appointment, length of interview, mode of cancellation and the procedure to be followed in case of in-

ing remains totally constant and unalterable) makes it possible to take up the treatment challenges with firmness termed as *limit-setting* in the analytic situation.Compassion and understanding, are the basic requirements. Counter-transference issues and the ways in which therapeutic impasse can be prevented by the effective technique while providing free psychoanalytic treatment should be understood properly.Thus, a larger number of patients can, be benefited without any bias on the part of the psychotherapist (with an attitude of *scientific objectivity*). Counter-transference evokes certain attitudes and feelings towards the patient which the therapist becomes aware of either in the therapy situation or outside therapy. This *awareness* comes through feeling extremely tired and exhausted after the session, getting alarms in dreams, missing an appointment or giving more time and attention to a particular patient, feeling dissatisfied or disgusted.The analyst's continuing scrutiny of her own counter-transference, frequently provides correct directions regarding how to address thecounter-transference issues promptly.

Who is *a suitable* patient for psychoanalytic psychotherapy is an important consideration. The reader must not draw the erroneous conclusion that the above mentioned patients are untreatable by any means. For example, alcoholics being poorly motivated have been found untreatable by psychoanalytic therapies (Blum 1966). This, however, cannot be and should not be *generalised*. Other methods of psychotherapy have been found effective. Freud (1905b) had proposed that the ideal age for psychoanalysis is mid-20's to 30's and he felt *the persons over 50 were unsuitable* and described them as 'no-longer educatable'. It is interesting to note that he himself continued to study and write several creative papers in his octogenarian years!

The psychoanalytic literature on treatablity consists of writings that either do not define what is meant by treatablity or are inconsistent in their expositions. According to Paolino (1981), ''These therapists, with the courage to be honest with themselves will acknowledge that the *judgment of treatablity* is mostly made subjectively''.

The empathic therapist is able to perceive the patient's thoughts and feelings and recognizes their significance, not only for what the patient is experiencing at the moment but also for what may lie outside his conscious awareness. Only then the working alliance can proceed towards developing 'symbiotic-modes' of relationship. It is the *doctor*, (like a good-mothering person) who *initiates a close empathic communication*. As already mentioned, the regressive patient certainly makes demands on the therapist that endanger classical psychoanalysis as well as create counter-transference. The dehumanized trait in the therapist can produce certain reactions in the patient which preclude successful psychoanalytic therapy. Such behaviours are detrimental to the formation of therapeutic alliance. Therapists afraid of counter-transference involvement, prefer to keep a strict scientific neutrality. They may find 'corrective emotional experience' unscientific. Eissler (1950) had disdainfully even called it ''magic psychotherapy, opposed to rational therapy of verbal interpretations of transference''.

2.4.2 Corrective Emotional Experience

Corrective emotional experience is in opposition to the value placed on verbal interpretation and conscious understanding of the transference-neurosis or the role playing on the part of the therapist or providing the patient 'a sounding board' in the analytic session. Ferenczi and Rank (1925) had introduced this concept in psychoanalytic literature; Alexander and his followers (Alexander and French 1946) vigorously promoted this idea in brief psychotherapy. They felt that certain behaviours and non-verbal interactions have a greater impact in making the unconscious conscious than what verbal interactions, abreaction, free association do. Instead, by creating a corrective emotional experience with the help of supportive methods the *actual conflicting situation* of the patient could be uncovered. For example, a patient brought up in a highly indulgent and permissive manner in childhood can work-through the transference better in group psychotherapy session than in individual therapy. When other patients in a group resort to *mimicry/role playing* of the stereotyped picture of the patient's significant childhood-objects already elaborated by the patient with isolated feelings and emotions, it promotes *catharsis and brings out the forgotten memories* or even provides insight in the patient's blocked feelings and maladapted defense mechanisms. The author does not advocate gratification and adheres to *the rule of abstinence* even in group psychotherapy session (where a few patients may like to indulge in manipulative gratification of instinctual impulses in a subtle manner). The relative *neutrality* of the analyst requires to be maintained for sometime by non-intrusiveness, so that the *multiple transference* phenomena may develop fully and be analysed.

The author considers that the transference reaction of the patient is to be brought to his notice, understood and fully analyzed and not *gratified or manipulated*. The therapist should act like a loving, encouraging, disciplinarian authority. Even when the patients improve (*tranference cure*) they should be made to understand these temporary benefits as 'idealized emotional reaction'. This kind of interaction can be a source of newly built self-esteem and growth which liberates the patients from clinging dependencies/neurotic hang-ups etc., of the past. A *respectful attitude* on the part of the therapist through out the course of treatment enables the patient to become the *final judge* of his own feelings and experiences. The therapist should not give this insight by verbal interpretations but by providing the corrective emotional experience. The therapist's understanding of the patient largely depends on how the patient *starts feeling about himself* in the treatment. Therefore, the therapist should not be perceived by him as a powerful authority/*guru* who is the only one capable of correctly interpreting his feelings, impulses, experiences, fantasies, or dreams etc.

The therapist should not *manipulate* transference by changing her behaviour though this has been promoted by some analysts. In brief psychotherapy, these analysts advocate the setting of corrective emotional experiences, based upon their *own understanding* of the psychodynamics of the

core-conflicts of the patient. How can a therapeutic alliance develop if the *patient is unable to understand what the therapist is doing*? The relationship between the patient and the therapist is the most important factor in this alliance and it involves a significant amount of *cognitive understanding* and the ability to utilize it in working through transference. In the analytical setting the empathic relationship seems to revive some of the earliest aspects of mother-child relationship, which Spitz (1956b) and Winnicott (1956a) have stressed. In a very sensitive and penetrative study, Leowald (1960) brought out how the non-verbal elements of *mutuality* resemble the mother's non-verbal and growth promoting interactions with the child. According to Greenson (1967), "... the mother's selective, mediating and organizing functions aid the child in forming an *ego structure*. The mother's picture of the child's potentials becomes a part of the child's image of himself. A *similar process* occurs unnoticed in psychoanalytic therapy".

In the corrective emotional atmosphere provided by the analyst it may develop into a *non-neurotic relationship*. This relationship requires to be differentiated from the neurotic/psychotic transference reactions and seems to have important theoretical and technical implications in the analytic setting in keeping with the current knowledge of psychopathology. The following illustrations might help the reader to understand the transference reactions in the long term therapy.

Mr. D., 33 years old of above average intelligence, apparently had made a good social adaptation - in terms of a successful career (as a business executive) and marriage. He was referred for psychotherapy by a Senior Psychiatrist in private practice.

The patient, in the first session itself, made the connection that the therapist reminded him of his late mother, who had died suddenly, leaving behind the burden of the family on the patient (three unmarried sisters and father). After the death of the mother, the patient successfully executed the family obligations, namely, marrying off the sisters and then himself, getting his own house constructed and taking complete care of the chronically ill father (who had retired by then and depended on his son as he had on his wife). The patient, being the eldest son, was loved and respected by his family, tried to 'live like the perfect, ideal mother' in carrying out his responsibilities, but felt 'lost'.

He often felt that his late mother's spirit visited him, to console him in difficult times or to inspire him to make the 'impossible possible'. This description of the vision of the mother had the quality of a hallucinating experience, but with insight and judgment intact. The youngest sister also reported a similar 'version' of the mother at times of her crisis. Mr. D. often visited astrologers and tantriks *to know what his stars predicted and planned his life accordingly.*

Once the therapist fell sick and canceled the appointment. This happened to coincide with the winter vacation. The patient, after the long

vacation, met the therapist in a highly panicked state as if he had suffered a nervous breakdown during this period. Apart from anxiety and depressive complaints, he described having several dreams of snakes crawling over his body and creeping around his neck. He did not like to make any association with this dream content or feelings except that being a devotee of Lord Shiva, he was alarmed that the times ahead would be worse. It was apparent that the separation anxiety due to the long absence of the therapist had brought on oral-sadistic fantasies and intense hostility. But, instead of working through them, the patient acted out by terminating the psychotherapy which he had attended regularly for the last six months. But his wife contacted the therapist to report that he had resorted to meditation and yoga therapy along with the treatment provided by the psychiatrist in private practice (who had initially referred the case). The wife was sorry for his hasty decision and wanted his name to be included in the psychotherapy waiting list.

Later, Mr. D. made several attempts to get in touch with the therapist over telephone, as if he was in the middle of a crisis. However, he informed the therapist that he was doing very well and that his name should be struck off from the waiting list. The therapist could understand that the patient was avoiding the liability of 'transference psychosis'. He preferred to keep extreme infantile dependence on objects (on his deceased mother as well as on the ex-therapist); at the same time, his ego had the strength to attach and detach from a deep emotional bondage with them. The preponderance of aggressive impulses in this patient and his fantasies of omnipotence and omniscience had brought identity disturbances in him, which are characteristic of Borderline Personality.

The unconscious cognitive activation in transference reactions facilitates retrieval of memories. Since, in the psyche of the patient traces/fossils of object-relationship or Cathexis on words, symbols etc. remain dormant. In *academic psychology* there is a lot of criticism on the concept of *unconscious cognition*. Probably, there is a lack of *methodology* required for empirical confirmation of the concept in laboratory. However, this skeptical view has initiated a new look by cognitive psychologists these days (Erdelyi 1974, Greenwald 1992 and others). The major *research questions* associated with this unconscious cognition are:

* What are the limits of cognitive analysis of registered but unattended stimuli?

* What memory residues are established by such a stimuli?

Lack or failure of introspection cannot provide the individual levels of analysis in unconscious cognition and it requires: (a) language using organism, (b) a reflexive (self-describing) cognitive ability, (c) the existence of a valid reference description of one's experience (Greenwald 1992). The non-neurotic transference reactions seem to provide an 'emotional bondage' and a valid reference point to the patient in the analytic setting. In the author's

view (based upon personal analysis as well as on clinical experience of some groups of patients who kept up emotional bondage even after termination of therapy), it requires a new approach to understand the non-neurotic transference reactions.

2.5 Phases in Treatment

The actual course of psychotherapy varies greatly from one patient to another and rightly so. Yet, the sequential flow of this process, as done traditionally, has been subdivided into the initial, the middle and the termination phases. This *sequential process* will enable the reader to appreciate some of the concepts of the psychoanalytic therapy discussed earlier (See Wolberg 1967, Weiner 1975). An understanding of the sequential process will explain *when* and *how* various phenomena occur and *what* is to be done about them. They require *different strategies* to be adopted according to the phase of treatment. For example, the therapist's interpretation of resistance could easily be given in the middle phase of treatment but in the initial phase there is constant exploration.

The reader should view this section as a *map* of a new city one is passing through which will enable one to identify the successive landmarks, the expected difficulties and the means of over coming them. But one's own clinical judgment is crucial and most helpful in the process of psychotherapy. One should remember what Freud had advocated long back that, as in the game of chess, only the opening and some typical final moves can be taught but not all that goes in between. Similarly, actual analytic work cannot be taught through books or teachers. A great disadvantage in learning the analytic work through reading is that one is unable to discover one's own procedure, suitable to the type of patients and the setting one works in. The therapist remains unaware of her own preconscious and unconscious processes which are the most important tools in the analytical work or indulge in 'wild analysis' of hasty and undisciplined interpretations (Freud 1910).

2.5.1 Initial Phase

It begins with the arrival of the patient on being referred to the psychotherapist who learns about the patient's presenting complaints and the detailed history in the words of the patient himself (See Section 2.4). In the hospital setting the therapist may acquaint herself with the case-history from the patient's case-file. She can also involve the patient in collaborating or rejecting the given clinical judgement (unless she has strong reasons of disagreement with the previous diagnosis and the line of treatment). She should also gather further information from various sources such as from the accompanying persons, family members etc. (especially in the case of psychotic patients). For example, one may begin as follows:

Therapist : I note you have been coming to our hospital for some time. In what way can we help you?

Patient : So far nobody could cure me. I have been taking various medicines for a long time... it seems that the doctors are tired of me.

Therapist : Do you know the medicines you are taking these days and why?

Patient : Oh, I take drugs when I am in great pain usually to avoid the various problems I have been having for a long time.

Therapist : Which other treatment do you take these days? How do you reduce your pain?

Patient : I do relaxation exercises. I have learnt yoga also... But nothing has helped me so far. I have acute pain and can't concentrate on anything, even on the relaxation exercises.

Therapist : What else helps you...

Patient : I don't know... you tell me ?

Therapist : O.K. You want to find out what makes your mind and body so tense. Would you like to tell me what is bothering you these days?

Patient : I have a number of worries. But to tell you the truth, the most important is my pain.

Therapist : I understand that, but you are making a distinction between body and mind. If you talk about your worries, your body may feel comfortable also.

After the therapist has identified the major complaints and worries of the patient she involves him in talking about them all the while listening with empathic understanding. This exercise conveys warmth and respect to the patient from the very beginning itself. The message to the patient that his own collaboration in making the therapist understand the symptoms in terms of present, past and future expectations, the stresses and strains, the coping mechanisms and his expectations from himself etc., will be helpful in the therapy. Apart from eliciting the previous history, the therapist should look into the *purpose/crisis* situation precipitating patient's visit to the hospital. The therapist should focus attention of the patient and get further information on the seriousness of the crisis situation/complaints. However, if he raises too many issues or multiple complaints, the therapist should take up only one or two issues, explaining politely why everything cannot be covered in one session. The therapist, after a empathic listening, *summarizes* whatever the patient has been saying while conveying warmth and respect to the patient this exercise clarifies the diagnostic issues.

Menninger (1963) advocated that *diagnostic evaluation* in an initial interview is an integral part of psychotherapy for those patients who continue treatment, not just as a prelude. On the other hand, if the therapist concentrates too much - encouraging the patient's initiative for free association or free floating talk, at the expense of not asking any diagnostic questions (about her concern for diagnostic formulation), she may inadvertently communicate disinterestedness. This listening with the *third ear* means that the on-going evaluation of the patient during psychotherapy is a continuous process. It

is not essential that we first screen a patient properly and then allow him to talk in a free floating manner. It depends upon his ego-strength and disturbances brought in functioning due to the present psychopathology. Rather, the therapist uses *appropriate strategies and tactics* according to the clinical needs (See case of Mr. A., Section 2.5.2.3).

While providing free-psychotherapy, the therapist should assess, in the initial phase itself, a patient's capacity to participate and benefit from psychoanalytic therapy. She should also evaluate whether to provide long term or short term therapy. There are *three major criteria* for undertaking analytical psychotherapy:

* Whether the patient is motivated for psychotherapy,
* Whether he can reflect and talk about himself, and
* Whether he has retained a generally well-integrated level of person ality functioning, despite his difficulties.

Usually the patient's capacity to reflect and talk about himself is assessed while conducting an in-depth interview. It has already been emphasized (Section 2.4.1) that, in the author's experience, this requires certain innovative techniques of probing (other than the patient's talk - verbal material), which may or may not exhibit his capacity of reflection. From the beginning the therapist should be careful that her *style of interviewing* is not based upon *direct* questions and answers in order to formulate only a differential diagnosis. The therapist starts the interview with *empathic listening* allowing ample opportunity for the patient to *pause and reflect* and to bring out ideas at his *own speed of thinking*. She may then pursue the directions the patient's thoughts take. She picks up the *verbal and nonverbal cues* with sensitivity which enable her to assess the patient's ability to reflect. At times, the therapist can become a model of reflective behaviour, offers a superficial interpretation or simply recasts what the patient had been saying or puts into words the patient's feelings which he was trying to share with her, e.g.,

Patient : I do not know what else to tell. They (Resident doctors) asked me many questions. The senior doctor also examined me thoroughly and now has asked me to see you.

Therapist : I know (points to the file). You must be quite tired of all these long discussions. Yet no one tells you what the matter is with you and what has to be done about it, isn't it?

Patient : Yes, I came here from a distant town. I am staying with a relative. How much more time will it take to know what my illness is?

Therapist : One can understand your difficulties. It is quite natural to get fed up and be angry.

(Patient sits silently and changes his position, in a fretful manner, to the edge of the chair - as if wanting to leave the room).

Therapist : You seem to be all prepared to leave, but you say you have been waiting to be seen since the morning ...

Patient : That is true. The doctors asked me many awkward questions, which have no relationship with my problem.

Therapist : Yes, your own feelings about the problems are more important and nobody seems to want to know your own views...

Patient : I can tolerate a lot but... (Starts crying, but tries to hide his tears. Therapist waits for sometime for the patient to settle down).

Patient : I should not have cried ...

Therapist : Is it because it is a sign of weakness?

Patient :Yes... I am reminded of my childhood. Whenever I cried, I was scolded by my father. My mother was scolded even more for making me a weak boy. She was very fond of me... She died recently.

Therapist : I am sorry. Tell me more about her.

A *depressed* patient cannot put his thoughts and feelings into words easily, due to *psychomotor retardation*. Although, as in the above example, the patient could talk spontaneously about the details of the sudden death of his beloved mother, probably due to the *transference* phenomenon.

The reader may like to know how to ascertain whether it is transference phenomenon? Several factors play a role in its determination for which various psychoanalytic explanations have been put forth. However, the most outstanding features of transference reactions are their *repetition*, resistance to change and *tenacity*. It is said that transference is 'reliving of the repressed past'. The warded-off impulses (sexual and aggressive) seek regressive and distorted channels in their attempt to gain consciousness. Freud (1920) and other psychoanalysts (Fenichel, Greenson and others) have viewed it as a means of achieving belated *mastery over warded-off impulses* - a compulsion to repeat the past and reliving it without knowing (memory).

In analytical setting one addresses transference reaction only when *working-alliance* has been properly *established* and the therapist is sure that it can be *demonstrated* to the patient since it is on the surface of the preconscious of the patient. *Probing questions* like: "You seem to be avoiding talking about some matters. Is it because of your feelings towards me? What is holding you back?" or "You seem to be afraid in opening the intimate feelings you have been experiencing here", are necessary when transference seems to create resistance in the analytical work. Otherwise, transference reactions are to be safeguarded (based upon the principle of protecting the patient's relationship with the therapist so that he can develop greater variety and intensity of transference). The therapist should be a 'mirror' for a patient to reflect and talk spontaneously, uncovering his unconscious (repressed history, the antecedents, origins, purposes and interconnections of a given transference reaction).

In the clinical setting, *transference reactions* are usually not accomplished in a single session alone; rather, transference is a *prolonged devel-*

opment during psychotherapeutic process. It requires an assessment of the 'optimal timing' for therapeutic intervention, especially when the patient is *ready to observe* this psychological situation and the therapist intervenes when she feels that he is aware of this development since reactions are *readily accessible* from his *preconscious*. It means that there is a split in the patient's ego; one part can observe what the other part is experiencing and the therapist has gathered enough evidence to demonstrate its meaning (causality of this psychological phenomenon). How-so-ever, the therapist has reasons to indicate his irrationality to the patient; transference reactions are bound to create resistance during future analytical work. This *intervention* is aimed at:

* correct reconstruction,
* accelerating the process of working-through, and
* providing a corrective emotional experience to the patient for working-through his neurotic conflicts and hang-ups.

But it is better that the patient spontaneously recognises such phenomena. This is the reason why the therapist likes to let the process prolong itself and get intensified. However, there is a danger that transference may get into *transference-neurosis - a source of prolonged resistance and flight from treatment in psychoanalytic psychotherapy*. Rather, one should take the position advocated by Freud, "The first *aim* of the treatment is to establish a *rapport* with the patient and this can be done only by developing an attitude of sympathetic understanding". It shows the most difficult requirement of psychoanalytic therapeutic work is the alternation between temporary and partial identification with the patient (empathy) and a return to the distant position of the *observer and evaluator*. As a *rule* of thumb, one should address transference only when working alliance has been established and the patient has a reasonably strong ego so as *not to flee* from the treatment.

In the initial phase, the analyst uses *silence* and also *active intervention*. Those who use silence to an excess or pursue active measures of opening up patients in the initial phase itself, often find that patients are unable to continue long term therapy (2 to 5 years duration). While providing long term therapy one should also evaluate the total life situation of the patient whether he can afford to come for a long time or not*. The problem of treatablity in short term and long term therapy is that of a *complex interaction* between the patient, the therapist and the analytical situation. However, from clinical experience we know that certain diagnostic groups make use of special types of defenses and accordingly pose problems of resistance in any form of therapy. One is required to *notice such defenses in the initial phase* itself and plan appropriate strategy for not getting into therapeutic impasse. In this

* While evaluating a case for psychotherapy, the author insisted that the patient doesn't make any major changes in his life situation, e.g., moving to a new city after transfer, marriage, for higher education etc., during the course of therapy. This brought down the drop out rate of patients.

In the traditional Indian culture, *child-rearing*, physical proximity (including sleeping in the same bed) and social interaction are ***maximum with the mother*** - till the second child arrives in the family. In the early development, the child is seldom left alone to explore, which tends to *inhibit separation and individuation* from the mothering person(s) and family members. Even an *adolescent* seldom gets *freedom or independence* to search for a career, for a sexual partner, to leave home or to take decisions as in the West. Rather, he stays embedded in his parental family or the extended family. Yet, a rapid *social change* is taking place within the family life and one finds a large number of Indians are settling down outside their native places, in search of a better livelihood. This may become clear to the reader with the following details of Mrs. T.'s case, discussed in section 2.3.

After Dr. M. (the Resident) left suddenly, Mrs. T. started taking active interest in her treatment by relating dreams depicting oral derivatives (eating food, cooking etc.). She talked of her interpersonal problems, especially of the adjustment problems she had faced while staying with her orthodox in-laws and of assuming role obligations of a housewife. She had perfectionist expectations from self (harsh Superego), but felt unable to carry out maternal-role all alone in a nuclear family set-up (due to symbiotic attachment with her mother).

One day Mrs. T. came for the session and openly expressed her perplexity about how the therapy would help her as she found the therapist busy noting down her dreams. The therapist asked her, "If you feel this treatment is not helping you, why don't you stop it?"

In the next session Mrs. T. came late and expressed her hurt feelings over the therapist's remark and sobbed bitterly for some time. She related the following dream, which brought out another area of her current concern.

"My husband is having an illicit relationship with a girl and he has killed the man who was living with her. I am very anxious because he will be hanged. He is not so worried. He says he will give bribe. However, he will have to undergo some punishment".

The therapist, intuitively, felt that the word 'relationship' (sambandh) is quite important for Mrs. T., so she asked the patient to free associate on it. Mrs. T. showed her irritation and asked the therapist why she hadn't picked the word 'hanged'. However, Mrs. T. began to work on this word and talked at length regarding the friendship of her husband with a girl of loose morals, living in their neighbourhood. She described the girl as 'easily accessible to the men in the factory' and how her husband flirted with her. The patient was completely blocking her own feelings so, the therapist remarked, "You must be feeling terrible these days". Mrs. T., becoming quite defensive, said, "My husband would come and tell me everything. Who will not like to enjoy with a cheap girl?" From this point, she changed the topic and started talking about

the movie she had seen with her husband, his friend and the friend 's wife the previous night. Mrs. T. felt quite embarassed to see the depiction of un-inhibited sex and violence in the movie. However, in the session, she unknowingly made comparisons (with feelings of envy) with women who enjoy sex.

In subsequent interviews, Mrs. T. related some dreams connected with toilets (Anal derivatives). During association, it became clear that she was quite dissatisfied with her toilet being used by one of her neighbours. Although she could easily stop this practice, she was unable to do so due to the fear of gossip in the neighbourhood. This led to the opening up of her relationship with her neighbours and brought out her ambivalent feelings. Socio-economically she felt superior and felt threatened by the crude and unsophisticated behaviour of her neighbours. On the therapist 's suggestion, Mrs. T. put a stop to the neighbour using the toilet.

The treatment was suspended for a week while she went to attend the ceremonies on the death of her brother-in-law, who was cancer patient. On her return, Mrs. T. could easily share her concern for the widowed sister's family with the therapist. She described her sister as a care-free person with a 'selfish nature' and how she could extract the best from their parents as well as from her in-laws. In comparison, Mrs. T. described herself as the 'conscientious type'. In this context, she recalled an incident from her childhood, occuring when she was about 6-7 years of age:

''One day I had forgotten to cover up milk and served it to everyone. Later I saw a lizard floating in the pot. I panicked thinking that all those who drank the milk might die. Thank God, nothing happened.''

When a patient is able to talk *productivly* in the session like Mrs.T., the treatment is *ready for progress* from its *initial* to the *middle* phase. To begin with, the therapist tries to *fill-in the emerging picture* of the patient's personality structure and dynamics by focusing his attention on whatever ideas come to his mind, but she also tells the patient to elaborate the details of his current life as well as the details of the past. This *collaboration* requires probing by the therapist into the patient's personal dimensions, calling attention to what is not stated and encouraging a balanced expression of thoughts and feelings in the conscious and the unconscious.

2.5.2 Middle Phase

The middle phase characterises shifting of the efforts from learning about patient to helping him to *learn about himself*. It has been advocated that, in the middle phase, the therapist should concentrate on *communicating her understanding* to the patient. The main tool of communication in analytic psychotherapy is said to be 'interpretation'. However, in the actual therapeutic process it is difficult to conceive what the therapist had been doing from the start while sitting with the patient and empathically listening, but was not

able to help him. In return, the patient might have already recognised and brought about behavioural changes in himself (in terms of *cognitive* and *affective* changes). Relief/modification and removal of symptom(s) stand testimony to the effectiveness of patient's own participation. The therapist simply proved to be a *good catalyst*.

2.5.2.1 Interpretation

Interpretation can be defined as an attempt to expand a patient's conscious awareness of himself by pointing out unconscious determinants of his behaviour (Weiner 1975). This awareness is required for understanding the *psychic content and conflicts* which have been warded off by the formation of symptom(s). Probably it is to verify and help the patient to work through his deep-seated neurotic conflicts that the therapist is required to give *interpretation*. However, a search for and mere removal of symptom(s) is not the aim of psychoanalytic treatment. Through interpretation the unconscious meaning, source, history, mode and cause of a given psychic content is provided by the therapist. This may enable the patient to clarify the *connection* between the past and the present mental states. The therapist has used her own insight, empathy and intuition, as well as, theoretical knowledge of psychoanalytic theory while making an interpretation. The therapist's endeavour is to go beyond the readily observable and to assign meaning and causality to a psychological phenomenon. As stated earlier, the *author did not reconstruct psychic events* on the basis of *metapsychology* of psychoanalysis but she interpreted the meanings of unconscious psychic events in the form of *simple communication* and awaited the patient's expected responses and reactions both, in *terms of cognitive* and *affective affirmation* - whether her 'interpretation' is valid or not. Thus, this process occurred mostly in the middle phase of the treatment - when prolonged clarification led to an interpretation with a subsequent clarification. For example, in the case given in the section 2.3, Mrs. T. recalled an incident which occured when she was around 6-7 years of age. She had undergone a panic anxiety attack when she saw a lizard floating in the milk-pot as she had forgotten to cover it. She felt relieved in the morning to see that no ill had befallen any of her family members. After the recall of this memory, the patient *regressed* back to obsessive symptoms which had subsided earlier. In the subsequent session, she brought along a significant piece of information that her grandmother-in-law was left behind by her husband (who had gone out of station) in the patient's care. The therapist *spontaneously* made the connection that Mrs. T.'s anxiety was unbearable for her as if she herself had been *abandoned* by her husband, due to her intrapsychic *childhood guilt feelings*.

Thus, for using the tool of interpretation effectively the therapist not only ought to be familiar with *the ego-strength* (see Table III) and dynamics of the patient but also with the nature of the therapeutic process based on one's own clinical judgment viz.,

* the timing of when to interpret,

* how and what to interpret,
* effectiveness of interpretation, and
* process of working through .

Table III: Ego functions and some of their disturbances to be monitored in psychotherapy process

EGO FUNCTIONS	DISTURBANCES
1. Relation to Reality	**1. Disturbances** in relation to **Reality capacity**
A. Adaptation to reality	
a. Differentiation of figure and ground	a. Inappropriate behaviour with subjective or objective difficulties
b. Role of playing	b. Inability to cope with deviations in normal routine
c. Spontaneity and creativeness; regression in the service of the ego.	c. Failure in social adaptation; rigidity
B. Reality testing	**B. Disturbances in reality testing**
a. Accuracy of perception	a. Projection, rationalisation,denial and the distortion of reality by hallucinations and delusions
b. Soundness of judgement	
c. Orientation in time, place, person.	
C. Sense of Reality	**C. Disturbances in sense of reality**
a. Good 'self boundaries'	a. Feelings of estrangement and lack of spontaneity
b.Unobtrusiveness of ordinary functioning	b.Excessive feelings of deja vu
	c. Oneirophenia
	d. Cosmic delusions
	e. Confused body images
	f. Intrusion of self as subject or object
	g Physiological manifestations
2. Regulation and control of Drives	**2. Disturbances in Drive Control**
a. Ability to engage in detour behaviour	a. Conduct and habit disorders (temper tantrums, nail-biting, etc.)
b.Frustration tolerance (neutralization of drive energy)	b.Accident proneness
c.Anxiety tolerance	c. Excessive impulsivity
d. Integrated motility	d.Tension states
e.Tolerance of ambiguity	e. Catatonic and manic excitement
f. Sublimation	f. Psychomotor slow-up of catatonia and depression
	g.Lack of or incomplete acquisition of control of excretory functions
	h.Physiological manifestations
3. Object Relations	**3. Disturbances in Object Relations**
a. Capacity to form satisfactory object relations	a. Psychotoxic and psychic deficiency diseases (in infancy)
b.Object constancy	b.Narcissism, autism
	c.Symbiotic relationships
	d.Anaclitic relationships
	e.Hyper-cathexis of the self; ambivalence, fear of incorporation, sado-masochism

EGO FUNCTIONS	DISTURBANCES
4. Thought Processes	**4. Disturbances in Thought Processes**
a. Selective scanning	a. Thinking organized & compelled by drives
b. Ability to avoid contamination by inappropriate material or drives	b. Preoccupation with instinctual aims
c. Good memory	c. Autistic logic
d. Sustained ability to concen trate	d. Loose and "nonsensical" type of associa tive links
e. Abstracting ability	e. Distortion of reality
	f. Lack of referents in time and place, anthro pomorphism, concretism, symbolism, syn cretism, etc.
	g. Magic thinking
5. Defensive Functions	**5. Disturbance in Defensive functions**
a. Repression (as a barrier against external and internal stimuli)	a. Emergency of primary thought process
b. Sublimation, reaction, formation	b. Over-reaction to stimuli
c. Projection	c. Deja vu experiences
d. Denial, withdrawal and other defenses	d. Lack of drive control
	e. Frightening hypnagogue phenomena
	f. Increase in parapraxes
	g. Impairment in emotional control
6. Autonomous Functions	**6. Disturbance in Autonomous Functions**
a. Perception	a. Corresponding impairment of these ego functions
b. Intention	
c. Intelligence	
d. Thinking	
e. Language	
f. Productivity	
g. Motor development	
7. Synthetic Function	**7. Disturbance in Synthetic Function**
a. To unite, organize, bind and create the ego's ability to form Gestalten	a. Tendency to dissociation
b. Neutralization	b. Inability to tolerate change or trauma
c. Sublimation	c. Inability to 'bind' psychic energy
d. Somatic 'homeostasis'	

(Source: Condensed and abbreviated from Kellerman H and Burry A, 1991).

In textbooks of dynamic psychotherapy, the interpretation has been classified in increasing order of its potential impact on a patient:

* as a probing question,
* clarification,
* examination,
* confrontation,
* interpretation.

The interested reader should read more about these Ego functions and their Disturbances (Greenson 1967, Weiner 1975). However, the *resolution*

of resistances through interpretation in psychoanalytic psychotherapy is ***essential*** because it conveys something ***new*** to a patient about himself. The reader should remember that 'resistance' is anything which interferes with the treatment and it is more often *unconscious* than conscious. There are five kinds of resistances:

* ego's unwillingness to give up repressive counter-charge.
* ego's reluctance to renounce a symptom due to secondary gain.
* transference resistance (an ego resistance) as an attempt to evade recollection through re-enactment of infantile experience.
* id-repetition-compulsion: though analysis seems to be completed and the ego resistances broken down, the repetition-compulsion often causes a continuance of the transference neurosis (in connection with this term the phrase'working through' has arisen).
* the need for punishment arising out of the demands of the superego.

2.5.2.2 Resistance

In order to make the unconscious resistance a *conscious process*, or cognitive-affective and even to the extent of behavioural restructuring, it is possible only when the patient is ready to make a move and has full confidence in himself. Some patients do get into severe depression or mourning-experiences as if they are defending themselves by *introjecting aggression*. Also, the highly narcissistic patients, when given a mild interpretation, react as if it challenges their self-esteem. They often tend to *act-out* or leave psychotherapy in the middle phase. The author found that they were able to work through their problems, after some interruption in the treatment as if they required 'time as a healer'. On the other hand, ready acceptance of interpretation should not be concluded as being effective. The therapist should judge by looking into whether a patient understands the interpretation's wider implication and uses it for generating a new self-image with confidence and whether he starts exploring the other aspects of his life neglected till then. Often, the patient brings into the therapy session the 'here-and-now' situation - a curiosity, enthusiasm and need for autonomy and independence with ***mixed feelings*** of anxiety and perplexity. In clinical practice, ***effective interpretations*** are those which the patient accepts as an 'insightful learning', and is able to bring about changes in his inner feelings, thinking and behaviour on his own. Yet, to give up maladaptive part of self, through interpretation of the therapist, does require ***repetition on several occasions*** and in different ways till the patient is able to work through the problems. Thus, the cumulative experience gradually allows one to change; it is called 'working-through' or *ego-work*. It is viewed as a significant task to be carried out in the middle phases of psychotherapy.

Often it is presumed that insight will bring on behavioural change but in clinical practice we see a good insight without accompanying sound judgment may enhance anxiety prone behaviour. The role of working-through

in translating 'insight learning' for behaviour change is an important part of psychoanalytic treatment. One impediment is the motivation of 'repetition compulsion' in which patient wants to be rooted to the past maladaptive ways as well as negative feelings and emotions on which the patient had little control previously. But now he seeks to bring about changes in thinking (cognition), feeling (affect) and action (motivation). Working-through is a process of personality-reconstruction and of positive growth and not merely a cognitive restructuring or insightful learning. This process of working-through can get further blocked by some issues of transference-resistance and counter-transference. Thus, resistance and transference in the middle phase, have to be viewed as interference in the analytical work. Such resistance, should now be differentiated from the situations in which the patient consciously opposed psychotherapy due to some rational thinking or irrational belief system. Even when treatment-alliance has been well established, the patient has been heard and understood with empathy, interpretative work has begun and some progress has already been made in working through of the maladaptive ways, yet the patient may be caught in self doubt, thereby creating an impasse.

There are several reasons why resistance has come to play a highly important role in psychoanalytic psychotherapy, and so it should be learnt under supervision. The resistance now requires the therapist to question:

* Why did the resistance occur at that particular point?
* What was the focal theme of the previous session?
* What made the patient resist?
* Why did he start resisting?
* How does he manifest the resistance? Does he talk too much about insignificant matters, too little on important events of life and blocks feelings or self-disclosure? What is his style of coping and covering his anxiety, (e.g., expression, denial, character armour etc.)?

Since resistance can also be due to transference (both positive and negative), it enables the patient to express his strong feelings of love or hate towards the therapist. Yet it narrows down the range of his self-awareness and self-report in the treatment. For example, he may resort to acting out, resort to flight into healthy adjustment or isolating the therapy from the real life so that nothing from the therapeutic interaction influences his real life situation.

The manner in which the therapist addresses the problems of resistance and resolves them during the middle phase has significant impact on the further course of psychotherapy and its outcome. The commonly recommended ways of resistance analysis are:

* allowing the resistance to build up,
* circumventing the resistance,
* exploring the resistance,
* breaking the resistance.

Allowing resistance to build up

As a rule, unless the patient is in a position to appreciate that he is resisting and the therapist has enough information to focus his attention on it, the therapist should not respond to resistance. Substantial and manifest behavioural cues are necessary to draw the attention of the patient. For example, a usually cooperative patient starts coming late or ask for cancellation of appointments or wants to leave early suddenly remembering some important work. In the author's view, while providing free psychotherapy, the therapist should not wait till resistance manifests and starts obstructing the therapeutic work. Rather, the resistance should be clinically noted and addressed frankly. Moreover, patients should not be led to see this passivity as a sign of weakness in the therapist. Marked resistance in the psychotherapeutic process, if left alone, can convey non-commitment, as well as it tends to create counter-transference.

Circumventing resistance

Responding frankly to resistance does not exclude circumventing it by helping the patient to understand that a particular content of talk is making him embarrassed. In that case either the therapist provides knowledge or reassurance and supportive help in matters of private topics (such as sexual matters) which ordinarily patients do not ask for directly, in our cultural set-up. Yet, these topics have to be handled in a matter-of-fact manner like other areas of concern.

Simply calling the attention of the patient to the problems, without providing support or attempting to explore the origin and the meaning of resistance, especially in free psychoanalytic psychotherapy, can create problems. The patient is usually dependent on the therapist and might not say anything openly, but in the long run, his compliance with authority may create more problems.

This approach could be adopted only in the course of intimate communication, in a natural and mature manner leading towards establishing a better working alliance. For example, the therapist may say, "If you feel this treatment is no good, why don't you leave it?" Generally patients respond well to this attempt at calling attention, when it is aimed towards further strengthening the therapeutic-alliance. This is an honest attempt not to waste anyone's precious time. Every patient has a right to leave treatment if it is not proving helpful to him. By calling his attention to it and giving him the right to decide makes the patient ponder whether he would prefer to continue to suffer or bring out his angry feelings in therapy. When such feelings are elicited by the therapist they give rise to negative-transference, which is very important at this stage. Such calling attention is to be avoided with psychotic patients, whose reality testing is poor. It should never be done before establishing a good therapeutic-alliance (accomplished with a good amount of analytical work).

Exploring resistance

When the therapist has enough clinical evidence that the patient is resisting and the content of his productive talk is indirectly suggestive of resistance, she should help the patient to perceive this by calling attention to the discrepancy between his behaviour or mood and/or thinking. It can be confirmed by some non-verbal cues like long silences, patient becoming fretful or anxious or his mood either depressed or elated. Once the patient also agrees that there is a change in his behaviour, only then the therapist moves towards exploring the resistance, in terms of its source, origin etc. One should go systematically from encouraging the patient to observe his behaviour, enabling him to explain it with rational or irrational statements instead of confronting him. The therapist should draw attention of the patient to the fact that she has been observing this lack of seriousness for some time, e.g.,

Therapist : Today you look tired and sleepy, did you sleep well last night?

Patient : I slept alright, but I had gone to see a late night movie with my Bua (father's sister), who has come to settle my marriage problems.

(Patient talks in a light manner about the movie for sometime, but seeing the therapist is not very attentive, changes the topic)

Patient : I wanted to go for a family picnic but could not. I remembered that I had to meet you today...

Therapist :Yeah...

Patient : Too many things are happening these days. I don't know which one to talk about... (sits quietly and watches the therapist...)

Therapist : Seems as if there is nothing for you to talk?

Patient : That's not true... I had a dream which I wanted to discuss with you, but suddenly it has slipped from my mind. These days I forget things often...It is said 'forgetting is as important as remembering'. (Starts laughing).

Therapist : You seem to have forgotten what you had wished to discuss.

Patient : As a matter of fact there is not much to tell you. Why don't you talk and let me listen today...?

Therapist : I am curious to know why you suddenly want me to talk while you only listen?

(Patient stretches her legs in a reclining position on the chair and watches the ceiling as if lost in deep thoughts...)

Therapist :You seems to be lost in your own thoughts.

Patient : I was debating within myself, why am I sitting here?

Therapist : Well, I have been observing your doubtful mood. It has continued since the last session. Do you recall what we discussed in the last session?

Patient : Oh yes, I was discussing that my husband has not called me

since he left the house and stayed back with his friend. He has sent me his salary cheque. But as you know very well that he is a very irresponsible and manipulative person. He feels he can buy anything with money... I feel that you also are pressurizing me ... you want that I should make up with my husband soon (watches the therapist's expression).

Therapist : Do I...? (in a surprised tone) Or, is this your own expectation which is making you feel doubtful here also.

Patient : You are right - there is a big struggle going on within me these days. One part of me wants to teach him a lesson and the other feels... I don't think that I am ready yet to face him (long silence).

Therapist : Seems as if a war is going on within you.

Patient : No doubt, you are a great support to me. On the other hand, these tensions are making me quite an impossible person these days. Everywhere... even my children tire me out.

(She starts talking about her children, her own behaviour and feelings).

The above example may give the impression to the readers that exploration is the most effective way of demonstrating resistance. As the process of working-through of problem progresses the patient not only learns about himself from his resistances but is also able to successfully control them. He views them as hindrances in his intimate relationship with the psychotherapist. Through resistance analysis in the middle phase the patient not only learns about himself but brings forth an honest confession as well. The proviso is that the therapist be alert in bringing to his notice what the patient has been doing unconsciously and which was a hindrance in development of interaction between them.

2.5.2.3 Transference

Transference occurs often in the form of resistance in the middle phase of therapy and requires to be clarified (to the patient's satisfaction). He is to be explained that his transference behaviour is unusual and springs from motives other than the ones apparent to him. However, at times, some peculiar reactions may be seen due to a progression of psychopathology (an attack of psychotic illness) during psychotherapy. The following case of Mr.A. illustrates this:

Mr. A. had a psychotic-break down when he had gone for attending a professional course (all the way from North to South India). After a short treatment in the psychiatric hospital, he had to discontinue his studies when he was sent back home to take rest. At home, the patient refused to do any work. He was bed-ridden, socially isolated, complained of insomnia and lack of interest in work.

His father was a semi-literate person, running a dairy business in a semi-urban resettlement colony of Delhi. His eldest son was in Govern-

ment service. Mr. A. was academically the most promising amongst his six children. The father was a God-fearing man and took this mishap as his bad luck, but on the persuasion of Mr. A., took him to various doctors.

In the initial stages of psychotherapy, Mr. A. kept silent most of the time and refused to take interest in relating his past history or day-to-day activities and fantasies, except that he complained of a single symptom of sleeplessness. He yelled at the therapist whenever she probed into his previous mental breakdown or visits to various doctors. But Mr. A. was regular in keeping his appointments and reacted sharply to minor interruptions (made by any outside source) in the analytic setting. He was maintained on Eskazine as well as once a week face-to-face individual psychotherapy. Afterwards, group psychotherapy, once a week, was also started. The patient, after maintaining silent resistance for a long time, started showing interest in his studies again. He rejoined college, completed B.Sc. and M.Sc. degree courses, securing high marks. Later, he could get admission in Ph.D. (Chemistry) course.

After this period of recovery, there was a tragedy in his life. His father died after a brief illness. This was followed by the patient facing some problems in his joint-family set up, which he brought to the therapy session and could work on them analytically and maintained a good therapeutic-alliance for a long time.

After the intensive psychotherapy treatment of five and half years, the therapist was preparing him for termination. His overall social functioning at home and at college had improved. He went abroad to present his research work at an International conference. He was no longer on medication. During this period, the patient also started showing some interest in heterosexual relationship but used obsessive mechanisms to cover his omnipotent control over loved objects (probably to avoid psychic suffering caused by separation anxiety). At this stage, he started talking about his wish to stop psychotherapy (like his medication) although he was markedly dependent on the analysts.

He was also having serious problems in the heterosexual area.He did not have any sexual experience, except for a humiliating episode in his adolescence (a boy forced him into a homosexual act, which resulted in a flight from the scene). He confessed strong guilt feelings in the occasional practising of masturbation. He believed he had no sexual urge, rather unlike his family members.He had seen his parents indulging in the sexual-act and all his siblings were enjoying married life. He liked to utilise his sexual energy for higher studies. He, therefore, denied his sexuality and projected this interest on the therapist. So far, he acted-in within the therapy situation by refusing to work analytically and challenging the authority of the therapist by coming late for appointments and was not willing to explain the reasons for it. The therapist tried her best not to fall in this projective-counter identification reactions

pist contacted the treating physician and learnt that Mr. A. had stopped eating and talking, therefore, the family brought him for admission.

The borderline patients are famous for regression and maladjustment bordering on psychotic breakdown. Mr. A. moved from self-hate to intolerable rage towards love objects but separation from them gave rise to intense reactions. His transference was intense from the earliest stage of treatment and projected his idealisation and omnipotence on the therapist. His negative transference reactions could not be handled properly by either form of treatment alone which was realised when Mr. A. had gone into a relapse (psychotic breakdown).

2.5.2.4 Counter Transference

The subject of counter-transference has come into prominence recently even though Freud coined the term almost a century back. Like the term 'transference', it seems to be changing its meaning and the significance attached to it in psychotherapy. For the classical psychoanalyst, the term refers to the projection of her own unresolved libido on to the patient. It was an indication that the therapist had not been sufficiently analysed - for working with the specific case, wherein it had occurred. It was viewed, therefore, as a therapeutic error. For the later Freudian and non Freudian psychotherapists, especially the client-centered, a positive warmth towards the patient was considered a strong therapeutic agent and highly desirable.

Berman (1949) felt that a patient can sense the therapist's 'dedication' and that a desire to please the therapist is often a strong motivation in therapy. He pointed out that the analysts have the same feelings under threat that other persons experience but they are able to display a better control over their feelings. While Bordin and Cutler (1958) held that psychotherapy offers the therapists to meet their own two needs of nurturance and inquisitiveness which are related to measures of the therapist's defensiveness, commitment, intrusiveness and relevance of questions, Tower (1956), Little (1957) and others contend that not all therapist's affect (rapport) is Counter-transference and accept it as a useful part of therapy. Several psychotherapists advocated trying out some counter-transference reactions as a test of the patient's acceptance of reality. Luborosky (1952) found (a research study carried out at the Menninger Foundation) that the "better 13 percent of 247 psychiatrists-in-training succeeded in creating deeper relationships with more discussion of emotionally-laden material". According to Synder (1961), "Highly important in the consideration of counter-transference is the matter of trend in the affect which the therapist displays."

During the long process of psychotherapy, the therapist has to adapt herself to patient's inadequate motivation, resistance to therapy, defensiveness and inability to relate. These are variables of the patient, which also evoke affective changes in the therapist. Such hurdles impede the treatment and may also raise the therapist's own anxiety about the adequacy of a tech-

nique, theory, relationships and skills for carrying out psychotherapy. Especially for the beginner of psychoanalytic psychotherapy these could be issues related to counter-transference. These should be mastered gradually under supervision and personal-analysis but professional competence comes from understanding how to apply theory into practice. The reader should note that like our ancient philosophical search for the truth which requires us to be open minded, psychoanalytic procedure is said to be an enduringly open-ended exploration into unknown (Franklin 1990).

Counter-transference has already been described in previous chapters. It is an irrational reaction of the therapist to the patient's response, though some clinicians have suggested that all the therapist's feelings towards her patient constitute counter-transference. However, the author is of the opinion that feelings should be viewed as authentic and true as rational thinking. Much of the talk about empathic listening or providing 'corrective emotional experience' is realistic reaction to the patient's level of ego-functioning and to the disturbances in it (see Table III). The therapist must monitor them. She should also be equipped to control her emotional reactions in the clinical setting, according to the demands of treatment in the present state of psychopathology of the patient. Only when a therapist feels or acts towards the patient in ways that are neither part of the real relationship* or clinically justified by the analytic situation nor occassioned by real circumstances as part of a treatment contact only then, counter-transference manifested. For example, a patient observes that the therapist looks at her watch frequently, as if in a hurry to wind up the session. The patient brings this to her notice and interprets it as a sign of 'no further interest' in his case. Such a comment certainly provides a cue to the therapist to probe into counter-transference feelings. In other words, inability to keep time schedules, getting too engrossed or bored or tired are cues for counter-transference.

Counter-transference, like transference, follows a fairly uniform course. Research evidence indicates that therapists tend to respond with decreased effectiveness whenever the patients present material pertaining to their own conflicts. Premature termination increases when therapists have to treat patients with problems similar to the unresolved problems in themselves (Fielder 1951, Yulis and Kiesler 1968). The therapist's attitude towards her patients varies substantially over a period of time primarily in relation to the patient's clinical state (Rabiner et al 1971). In providing free psychotherapy the therapist's personal and professional interest, specific clinical research interest and need of sharpening clinical competence or for opening higher promotional avenues etc., may determine her attitudes and behaviour in psychotherapy. But they should not interfere with the therapist's commitment to patient-care. The therapist must be able to recognise such personal temptations and try to control them while conducting clinical work. Some enthusiastic trainees (Psychiatry) become unusually sympathetic and spend long

* The patient's 'observing ego' enables him to fantasize and regress, yet perceive the analyst as a neutral, a helpful and a kind professional.

hours patiently listening to the patient before a clinical case conference. But they do not show corresponding interest in the patient even when he was passing through a crisis situation. At times, they even show impatience and 'give instructions' to their patients to get well soon! Although the patient's adamant behaviour might be due to unconscious resistance or genuine disappointment with the treatment, such irrational ways of giving vent to feelings and confronting patients while treating them are certainly acts of anti-therapy. Similarly, failure to control one's amorous feelings and sexual impulses, at times, leads to seduction in the doctor-patient relationship. Unless such counter-transference reactions are recognised early and controlled, the therapist can get into disrepute.

It is obvious that a certain degree of self-awareness of one's feelings and impulses and control of specific gains and generalized emotive reactions are necessary for entering into any doctor-patient relationship. However, reflection on one's counter-transference feelings with a colleague (who is one of the clinical team for that particular patient) can circumvent human errors and can also promote one's professional growth. In the long run, a genuine involvement and commitment to psychotherapeutic work with various patients enables one to make a better selection of those patients with whom one can work effectively and gradually identify unresolved areas of one's own life. Sensitivity in counter-transference reactions makes the therapist take proper preventive measures and does not impair her ability of empathic listening or of providing corrective emotional experience to the patients. In this sense, professional work invariably promotes the therapist's personality growth and development throughout life even though psychotherapeutic work is carried out for the benefit of the patients only. As Freud (1937) wrote in his last paper, "If therapists continue treatment until the patient is 'cured' or has reached a state of complete freedom from neurotic inhibitions or concerns, the treatment will never end. More realistically, therapy will have reached its necessary duration when the patient's freedom from symptoms, anxieties and inhibitions have been approximately fulfilled".

Therapists should not be of the view that by undergoing personal-analysis one is free of one's neurotic disposition and blind spots of personality; rather the goals of self-understanding and self-realisation are life long processes. The therapist should be guided in individual cases by certain therapeutic set out goals which influence the duration of treatment. This perspective leads us to the final phase of treatment, viz., termination.

2.5.3 A Psychotherapy Termination

To bring the psychoanalytic therapy to an effective closure the therapist must be able to judge when the appropriate point of termination has been reached and what procedures to follow to enable the patient to consolidate the benefits from this work. The assessment of the patient made during the initial phase and the evaluation during the therapeutic process enables one to lay

down the specific goals of treatment to be pursued in terms of: removing/ modifying symptoms, the severity of subjective distress, changes in the significant life stresses with support system, personality reconstruction and the patient's own quest for self understanding and actualizing his hidden potentials. It may or may not be possible to achieve all the goals because, often, there are certain external circumstances in the life situation which may require premature termination of a case, e.g., a marriage problem getting resolved due to the compromise brought about with the in-laws, or the therapist's own professional obligations, other than psychotherapy work, which can necessitate transferring cases to another colleague or giving up of the work for a long period.

A successful psychotherapy is like striving towards goals but, necessarily not achieving all of them. Psychotherapy is a process of helping an individual to help himself. One should not promote this unreal intimate interpersonal relationship as a way of living life for the patient because that will promote dependency in him. Rather, the most important accomplishment of analytic psychotherapy is that the patient should learn the method of looking at himself and observe his past and current life experiences effectively and deal with the future in a self-assured manner. Patients often report sustained progress after termination of psychotherapy and a richer and more fulfilling quality of life. That does not mean that the therapists should first ensure completely that the patient has gained sufficient personality growth and self understanding and only then terminate the treatment. Although within the therapy period both the patient and the therapist try to see that certain maladaptive ways are given up and positive changes in life and its quality which can promote subjective well-being, are being brought in. Thus, the termination of psychotherapy depends upon the individual case improvement as determined by:

* the depth and intensity of the therapy carried out,
* the level of training and professional competence of the psychotherapist,
* biological factors as well as adverse childhood experiences precipitating adverse life events, social-support system and personality variables of the patient,
* the setting of psychotherapy (the duration of psychotherapy), to a large extent is determined by situational factors like, whether it is provided for an out-patient, in patient at hospital or in private practice, or as a brief consultation in crisis or within time limited framework, and if a fee is being charged or not.

At times, the length of therapy is also determined by the therapist's decision - whether it will be individual or combined with group, family or couple psychotherapy. The long term psychotherapy can vary from two years to several years depending upon the therapeutic context. Therefore, the more the uncovered thoughts and feelings become conscious during the

termination phase itself, the more the time necessary for psychoanalytic work. Those patients, who enter psychotherapy for serious and complicated long standing psychiatric problems usually require a more prolonged treatment than those who come for relatively minor adjustment problems or some precipitating recent stressful events. Generally, the greater the gap between the severity and chronicity of the patients' emotional problems and the improvement in various areas of personality functioning (which both mutually agree upon to bring about), the longer the process of psychoanalytic psychotherapy can be expected to last.

The extent to which the needs and expectations of the patients effect the duration of psychotherapy has led to the distinction between long term and short term psychotherapy. Recent research publications on brief or short terms psychotherapy studies report substantial improvement rate (Wolberg 1965, Sifneos 1972, Mann 1973, Malah 1976, Ashurst 1991). In general, these do not demonstrate any superiority of long term over short-term psychotherapy, although this absence of evidence is relatively confined to a few good studies (Luborosky et al 1975). Dose-response studies (Howard et al) of psychotherapy suggest that up to a point (between 10-40 sessions) the longer the therapy the better the out-come. But there is also a law of diminishing returns; more benefit seems to be in the early sessions and probably the 'bug of dependency' creeps in the later sessions which keeps the patient coming for therapy (especially those cases who have a poor social support net-work). Therapist should keep such a case for group psychotherapy if the minimum criteria for considering termination could not be achieved in terms of:

* the patient's capacity to continue independently and to observe and learn about himself,
* substanitial progress towards the therapeutic goal(s) set in the beginning of therapy could not be a achieved,
* resolution of the transference not arrived at.

The therapist and the patient, can both work in advance for termination of treatment and keep a fixed date with mutual agreement and end the treatment on the day due. This gives the patient a better involvement in treatment as well as an opportunity to work in the sessions identifying what kind of the changes or developments are required to be accomplished (therapeutic goal) before the termination date. In such cases, a kind of resistance is also bound to come in especially when a patient having become symptom free earlier, gets preoccupied with them again due to secondary gains in treatment.

Problems regarding secondary gains in an illness and resistance to becoming mentally healthy do come up and should be addressed again in termination phase. However, the therapist must provide special attention to the patient's need in terms of:

a) transference resolution

b) plan spaced termination method or time limited follow up of the case, once the psychotherapy comes to end on a fixed date.

Often, the decision that treatment is soon to be terminated raises fresh issues which may not have been covered so far and encourages the patient to discuss them. In such cases, the time between sessions can be gradually extended (the patient and the therapist do not meet for a month but the follow-up session may be prolonged from more than 45 minutes to an hour), so that the patient may discuss important problems and deal with them within a fixed time frame. Another alternative may be that a patient who was meeting once-a-week, may now be put on twice-a-week schedule and then on once-a-month for follow up schedule till the treatment is terminated.

In the time limited follow up the patient knows the exact date of termination but in spaced termination only the therapist can judge the final session. Certain patients do not prefer time limited or spaced termination. They can get into high separation anxiety of the degree that necessitates their visit to the therapist in a crisis or their families seek consultation with the therapist, as if they were under stress. The therapist should first refer these cases for proper psychiatric evaluation and avoid personal engagements with them during this period. Later she may take them up for fresh therapeutic work, because such patients might pose problems of counter-transference. Towards the end of his professional life Freud had recognized that psychoanalysis could not guarantee a permanent cure and that further episodes of treatment might be necessary if life circumstances led to new problems.

In the final phase, by becoming more of a real person as well as a well-wisher in patient's life, the therapist can help the patient in resolving the transference. Real separation is necessary because, in free psychotherapy in the Indian setting patients seldom undergo 'the type of mourning experience' which one observes with the Western patients. Our patients idealize the therapist in a hierarchical relationship of respect and this attitude which seems to continue throughout life and reverses itself if the treatment gets interrupted prematurely. For this reason, the therapist planning the terminal phase of work with a patient who is likely to resume treatment with another therapist/psychiatrist, should refrain from becoming too open regarding her future plans. As far as possible, she should prevent transference being carried over to subsequent treatment. In case the treatment is terminated due to the therapist's personal reasons (transfer or going abroad etc.) she should inform the patient of her plans in advance and ensure that the separation anxiety of the patient is being handled properly.

At the level of real relationship patients do show curiosity and ask several questions regarding the future plans of the therapist, but such sharing increases anxiety and insecurity in them about their treatment in future. Moreover, keeping in view that the patient may need further treatment the patient should be provided with names and addresses to contact and should be given summary notes, if asked for. In the author's experience, only in

forced or premature termination the therapist is called upon or bothered by frantic visits or telephonic calls: otherwise, the patients who have actively participated in psychotherapy and gained insight into what they were able to derive and what they could not, do well in life.

Only by testing out which techniques could suit the needs of a particular patient one can conclude what was effective or ineffective. There is a lack of follow-up data in present day psychotherapy, therefore, the immediate outcome of psychotherapy may differ from the long term effects. Research is required to see whether the full range of psychotherapies can meet the varying needs of psychiatric patients in the various clinical settings; or whether it is a question related to the level of training of the psychotherapist? A policy of psychotherapy training is yet to be formulated in India. It has already aroused much passion among Western psychotherapists about their varied stands (Holmes 1991).

CHAPTER III

APPROACHES TO PSYCHOTHERAPY

3.1 Place of Psychotherapy in Society

The rapid changes in social consciousness all over the world, which have been stimulated by the rise of human rights and feminist movement seem to have paved the ground for *psychodynamic approach* in contemporary Psychiatry. The psychological treatment can either be in the form of advice, psycho-educational instructions, environmental manipulation, sensitivity training, or through more formalized methods like behavioural therapies, behavioural modification, hypnosis, biofeedback or client-centered counselling including the oldest form of psychotherapy, namely, psychoanalysis. The demands of the modern society greater need and develoments in social sciences have given impetus to our efforts to understand theory and practice of psychotherapy.

Attempts to help people with their emotional problems have shown rapid progress in recent years, both in quality and quantity. Since psychotherapy has shown some successful results, the people have learnt to expect personal attention (when in distress) from a professional source rather than from traditional support-systems. An increasing proportion of the urban population readily comes forward to avail of this help - even at busy government hospitals and family courts etc. or from private psychotherapists who charge a heavy fee. Many psychiatric patients receive *a combination of psychotherapy and drugs* - although in some circles a naive view is still upheld that drugs and psychotherapy are incompatible. This trend, as in the West, may grow faster than the availability of trained therapists. Those who have been properly trained in psychotherapy find themselves in the fortunate position of being in demand. But lack of *proper training* facilities and accreditation may lead to unethical practices which can have harmful results. Thus in practice psychotherapy pays well - not only the professional but also

the inadequatly trained and unethical practioners. Certainly it raises strong feelings and emotional reactions in the mind of the public, particularly among medical personnel against psychotherapy and claims of independent practice of psychotherapy by non-medical therapists.

Psychotherapists deal with personal and intimate material which is bound to create either positive, negative or ambivalence to feelings in the patients and their associates. Therefore, not surprisingly, some medical text books, non-technical journals and magazines related to psychiatry and mental health publish articles for and against psychotherapy. Many people are also applying the principles of psychology in their daily lives. A lot more emphasis will be put on ways of *preventing the stress* and strain of modern living than on its treatment alone. Yoga, psychotherapy or other such measures for improving the quality of life as prophylaxis need to be incorporated in any branch of Modern Medicine since prevention is said to be better than cure.

3.1.1 Research Obligation of the Therapist

It seems that concern with emotions, adjustments and psychotherapy can be beneficial as well as harmful during rapid social change in developing countries. Acceptance of this profession increasingly makes it obligatory for the various types of therapists to demonstrate the *scientific bases* in their brand of psychotherapy of their understanding of emotional problems. The society, when it allows individuals with the personal difficulties to seek professional help also requires *provision to be made for research* along scientific lines for further examination and evaluation of this treatment. With community becoming more receptive, the psychotherapists must have adequately developed techniques in order to be able to demonstrate their *outcome results*.

In advanced countries this type of research work carries *an obligation* with it. This is becoming obvious not only to the recipients of psychotherapy but also to others who have educated themselves in this procedure. This trend has led to formation of various schools of therapies and creation of various groups of therapists who have discovered for themselves that the old ways of carrying out therapy are no longer satisfactory. The newer theoretical development and practices in psychotherapy has created many divergencies in concepts some of which are basic and some are superficial. The current status of psychotherapy seems to have given rise to a conflict even in the West, regarding: (a) the over all approach (which takes into account the interpersonal and the psychological aspects of any clinical situation), and (b) a set of specific methods of treatment for all patients.

In the general hospital setting, psychotherapeutic methods are often used as an adjunct. Whenever necessary, formal psychotherapy is provided by a few psychiatrists or clinical psychologists using varying therapeutic approaches: psychoanalytic, cognitive, behaviour therapy, yoga or hypnosis. Due to a lack of outcome research everyone seems to be convinced of

Luborsky's celebrated statement: "*do-do-verdict*: everybody has won and all must have prizes".

This discrepancy between different techniques yet similar outcome results has been called the *equivalence paradox* (Stiles et al 1986). A number of explanations have been put forward. Paul (1986) suggested that for each clinical situation the therapist should ask the question: what treatment and by whom is most effective for an individual, with a specific problem, and under the given set of circumstances? Paul's *matrix paradigm* implies an ideal in which psychotherapeutic intervention is matched with patient's needs, in terms of both illness and personality. Research evidence in the West confirms the clinical impression that introverts do better with analytical form of therapy while extroverts fare better with behavioural treatment (Bloch and Crouch 1985). Most psychotherapists however, by training and persuasion, adhere to a particular school. Probably because *eclecticsism* in clinical practice can be confusing and therapists while retaining flexibility get better results by practising one clinical method in depth rather than by trying to master them all (Luborsky et al 1975).

On the other hand, the first scientific question is: whether every psychiatric patient can benefit from some form of psychotherapy or not? Then come the indications for psychotherapy. If the patient can benefit from psychotherapy, then which technique is likely to be most appropriate and which therapist is profficient? Various attempts have been documented in the Western literature refining criteria for different forms of psychotherapy. Research evidence of these include - the efficacy of family and behavioural interventions in schizophrenia, cognitive therapy in depression and brief therapy, both, analytic and behavioural, in anxiety and in depression (Holmes 1991). Despite uncertainties the application of Paul's matrix paradigm remains elusive because most treatments contain a variety of therapeutic elements and are broad-spectrum rather than highly specific. Research evidence has failed to find major differential outcomes among the therapists. Howard et al (1986) showed that *good outcome* from all forms of psychotherapy is associated with three known factors:

1) a strong therapeutic-alliance in which the patient sees the therapeutic process in a positive light;

2) some degree of educational achievement, and

3) ability to remain in therapy for at least ten sessions which is viewed as evidence of motivation.

3.1.2 New Trends in Modalities of Therapy

As emphasised earlier, psychotherapeutic settings also vary widely these days: from indoor treatment at a Mental hospital/General hospital to outdoor treatment at a Day care mental health center/General hospital and from General hospital setting to private practice - where therapy could be individual, group, family, marital or any other. The length of psychotherapeutic

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treatment varies from one to two sessions to several years. The frequency of meeting could be *very brief or time bound* (once or more than once a week), depending upon the training, time availability of the therapist and the setting.

It is said that differences in the temperament of the therapists and variations in their intellectual, academic, as well as cultural backgrounds and the type of patients leave their imprints on the therapists' work. Although the major psychological theories have originated from a few dynamic personalities and institutions, the existence of their divergent views has distinct advantages as well as disadvantages for the developing speciality. *The schools* provided basic theoretical structure in the early developmental stages. These paved the way for the next stage of development of specific psychotherapeutic theories and methods. Comparative studies made in recent years show equally beneficial results by different therapists. If the variation in treatment procedures is as great as claimed, the similarities of results obtained by different therapists in terms of number and types of patients benefitted, cannot be easily explained. The *emerging trend* is to adapt, correlate and integrate, without bias, the contributions of the varied schools of psychotherapy. It is always the obligation of those practising an *applied science* to go beyond the body of established knowledge on which it is based. For example, while teaching basic psychotherapeutic skills, the emphasis is placed on accurate and empathic listening. But Carl Rogers and his associates were able to directly confront the dilemma which constantly troubles the supervisors: how to explain an enormously complex therapeutic process through systematic teaching of basic skills in a setting without the presence of the client/patient (Traux and Carkhuff 1967, Ivey 1968, Ivey et al and Simek-Downing 1980).

Research evidence from the West cannot and should not be applied as such. We, in India, should first gather our own empirical data. However, one is generally committed to the type of psychotherapy in which one is trained but the theoretical basis must be in relation to clinical modification in response to the needs of the client and on practical grounds. The therapist's *intervention techniques have been changing* from interpretation, direct measures of supportive, paradoxical, challenging to non-directive, nonverbal and even expressive modes of fine arts (including religion and *Yoga*). Most therapists use a combination of techniques and look forward to innovation and research. The goal of all therapies is to engage patients in the painful task of abandoning their maladaptive behaviour and help him to live a more meaningful and pleasurable existence. Various therapists differ in their operational models of human behaviour. Their therapeutic approach differs accordingly, and it leads to different treatment models. In this process, some therapists have adapted personal techniques and theories and seem to ascribe to them a *quality of universality* and regard them as fundamental.

In this chapter the reader will be familiarized with major approaches of psychotherapy which have some degree of different rules, techniques, for-

mats and cures or failures to their credit. With the exception of behaviour therapy in the treatment of certain Phobias no empirical research so far has demonstrated the superiority of one type of psychotherapy over another (Luborsky et al 1975). Most, if not all, psychotherapeutic approaches hold the fundamental hypotheses that a patient's feelings and behaviour are based on continuous and complex interactions with the therapist.

3.2 Psychoanalytic Therapy

With the advent of various forms of psychoanalytically oriented psychotherapy, in addition to psychoanalysis, the issue of *similarities and differences,* between psychoanalysis proper and other forms of psychoanalytic psychotherapy has become quite complicated and remains an unsettled controversy (Paolino 1981). Much of the literature that has been written specifically for psycho-analysis can be applied to psychoanalytic psychotherapy (and vice versa) and clinicians, who are unsure of the differences and similarities, use the terms interchangeably. The reader has already been acquainted with psychoanalytic movement beginning with Freud and the subsequent developments in psychoanalysis in the previous chapters. The issues raised by *Sharp Difference* (SD) and *Blurred Difference* (BD) perspectives, therefore, will not be discussed here, but the reader must keep in mind that there is an unavoidable conceptual overlap between and within each group, and in clinical practice *SD/BD distinctions*, do become artificial. Major polarities highlight controversial view points and define divergent perspectives within psychoanalytic psychotherapy on the question: when does the technique (although grounded in Freudian Principles) stray away from psychoanalysis and yet be called psychoanalytic therapy?

3.3 Dynamic Psychotherapy

The reader should note that the dynamic personality theory is most clearly represented in but not limited to the various approaches of psychoanalysis and allied forms of therapy. The dynamic theorists have conceived personality as an *energy system* whose chief work consists of activities that reduce tension. Two main sources of tension arising from the needs of the organism are the physiochemical requirements like food, water, oxygen, of pain avoidance, sex and the psychological needs of achievement, power, affiliation and self-actualization. Several theorists represented by Adler, Fromm, Horney and Sullivan (Chapter I), while acknowledging their indebtedness to Freud, also have invested personality with a social dimension equal to biological dimension. Thus, each therapist has her own independent school of psychotherapy, which is based on personality as an energy system and in that sense their approaches are called dynamic psychotherapy including the *Existential school* (L. Binswanger, Rollo May, M. Boss in the West and E. Hoch in India). Their concept of dynamic is not the usual (Freudian) one. The individual is viewed as neither the pawn of the environment nor the creature of instincts, needs or drives but one who has the *freedom of choice*.

He alone is *responsible* for his own existence. The most important contribution of the Existential viewpoint is that of *becoming*. It is based upon the philosophical premises of S. Kierkegaard, F. W. Nietzsche, J. P. Sartre and M. Heidegger, who advocated that 'existence precedes essence' as opposed to the traditional Platonic thinking. Existence is never static; it is always in the process of becoming something new or ever transcending itself. The goal is to become completely human, that is, to fulfill all the possibilities of *Desein* (a German word meaning: being-in-the world). Man's authentic living is his freedom to be. Although Binswanger (1963) and Boss (1963) were both trained in psychoanalysis and practised it for many years, their dynamic approach to human personality is not psychoanalytic therapy. In his book 'Existential Foundations of Medicine and Psychology', Boss (1977) says that all pathological symptoms, whether physical or psychological, are to be viewed as encroachments on and impairments of the free, open fulfillment of human existance.

3.4 Behavioural Therapies

Behaviour therapists are of the view that *abnormal behaviour* arises not because of internal pressures or external stresses (life events, lack of supportive environment etc.), but mainly because of *faulty learning* or not having learnt the right things adequately.

John B. Watson, the father of modern behavioural psychotherapy, published the case of 11 month old, Albert, in 1920. He could condition a fear response in him by pairing the appearance of a furry white rat with a loud noise. After a number of such demonstations, the child began to cry whenever the furry white rat was brought in front of him. The fear response could also be elicited without the accompanying noise. The same response could be elicited by showing the child similar stimuli like white hair, cotton wool etc. (Stimulus generalization). Mary C. Jones, an associate of Watson, devised methods of deconditioning anxiety responses by presenting the feared object while the child was engaged in a pleasurable activity (such as eating and playing with other children who would not respond to the object in a fearful manner like him).

The early work on animal models of conditioning by the Russian physiologist Pavlov (1927) which was developed in the laboratory setting, focussed on the treatment of anxiety disorders, especially *specific phobias*. This led to the refinements in deconditioning techniques by later workers, like: Wolpe, Lazarus, Rachman, Meichenbaum and others. Wolpe (1958) developed a strategy called 'Systematic desensitisation' in which phobic patient, after being taught deep muscle-relaxation, imagined fearful scenes arranged in an increasing heirarchy of anxiety. Lazarus (1966), a close associate of Wolpe, introduced behaviour rehearsal to enable patients to practise anxiety-producing social interactions in role-plays with the therapist incorporating various learning principles (Bandura et al 1963) - a strategy in

which the patient was encouraged to imitate the non-anxious responses of the therapist. This approach enabled socially phobic patients to be treated by *assertiveness training* method. Deconditioning was achieved by pairing the 'anxious response with anger'. Marks (1975) found that anxiety could be extinguished in a more direct manner, without the need for accompanying relaxation. He advocated a direct exposure to the feared object in graduated steps; the method termed as *exposure-in-vivo*. Rachman et al (1971) applied a strategy called *exposure with response prevention* to obsessive compulsive patients. They were encouraged to expose themselves to the stimuli they feared most (like dirt) without engaging in any anxiety relieving rituals (washing hands etc.) until the fear response subsided. Meichenbaum introduced specific cognitive strategy of *self verbalization* to assist the phobic patient to prepare himself for exposure to a feared object. A more advanced technique is a strategy that involves slowed breathing because the hyper ventilation and some other physiological changes increase the vulnerability to panic attacks (Clarke et al 1985).

Another behaviour therapy technique based upon the *Operant conditioning* model of Skinner (1938) is also called *Instrumental conditioning*. It has been applied to patients of psychiatric disorders. Certain abnormal behaviours can be maintained because they are positively reinforced. Skinner introduced the notion of the experimental analysis of behaviour. This enabled any behaviour, normal or abnormal, to be examined in terms of the context in which it occurs. The antecedents and consequences associated with that specific behaviour were examined along scientific lines similar to those employed in animal experiments of 'operant conditioning'. Skinner generalized that maladaptive responses to environmental stimuli could be learnt if those responses were reinforced by pleasurable consequences or could be through unpleasant consequences, such as reduction of depression, anxiety etc. The concept of operant conditioning (positive, negative reinforcements and extinction etc.) have been employed widely to mentally handicapped and autistic children probably because it is common sense that we participate more in those activities that induce pleasurable consequences and less in those things that induce unpleasant results (Freudian Principle of pleasure-pain). This has led to the development of scientific techniques of *Behaviour modification* but with *scientific procedures* of precisely defining the problem followed by a detailed analysis of the conditions that elicit the inappropriate behaviour, despite the patient's best efforts to resolve it. According to Kanfer and Saslow (1965) the steps involved in altering behaviour pattern are:

* Pinpointing the exact problem goal.

* Pinpointing the environmental factors that trigger or maintain problem behaviours.

* Defining effective coping behaviours already deployed by the person and his social net-work.

* Defining current levels of every day functioning.

person's characteristics are openness to experience, absence of defensiveness, accurate awareness, unconditional self-regard and harmonious relations with others. On the basis of extensive research on the therapeutic process Rogers formulated a general theory of interpersonal relationship which has been applied widely to family life, education and learning etc.

Nondirective therapy enjoys popularity among counsellors and is said to be fairly easy to learn; it requires little knowledge of personality diagnosis and dynamics for use in the course of treatment. It is brief in comparison to psychoanalysis. Rogers had also made an intensive controlled study of psychotherapy with Schizophrenics in a mental hospital (Rogers 1967). An increasing number of therapists of various theoretical persuasions have come to an agreement on the importance of the kinds of conditions and relationships about which Rogers wrote: "It is also worth noting that it is the way, in which his (the therapist's) attitudes and procedures are perceived, which makes a difference to the client, and that it is this perception which is crucial" (Rogers 1961).

Rogers added a new feature to the concept of growth when he emphasized that the forward-moving tendency can only operate when the choices are clearly perceived and adequately symbolized. A person cannot actualize himself unless he is able to discriminate between progressive and regressive ways of behaving. Rogers has singled out two learnt needs for special attention: the need for positive-regard and the need for self-regard. The former develops in infancy as a consequence of the baby being loved and cared for; the latter by virtue of the baby receiving positive regard from others. In client-centered therapy the person finds himself in a non-threatening situation because the therapist completely accepts everything the client says. This warm accepting attitude encourages the client to explore his unconscious feelings and to bring them to awareness. When the clients are given such an opportunity to express their probelms and their attitude in their own terms without any guidance or interpretation, they tend to talk in terms of the self. In Rogers' theory *the self is the central construct* and, in addition to *self,* there is an *ideal self* (what the person would like to be). In the safety of the therapeutic relationship, the hitherto threatening feelings can now be assimilated into a self-structure; which may require rather drastic reorganization in the self-concept of the client in order to align with reality of the organismic experience. According to the client-centered therapy, "He will be, in more united fashion, what he organismically is, and this seems to be the essence of therapy" (Rogers 1955).

There are many possible ways of expressing empathy. One way is to make a *reflective response* in the client-centered therapy. It consists of reflecting back to the client as accurately and sensitively as possible the awareness that he/she understands and feels what the client tries to express (implicitly or explicitly). The client checks this against his own experiences - perhaps in a way in which he had been unable to express alone. This method has extended teaching of the basic psychotherapy skill (Margison 1991).

The importance of this lies in recognising and helping trainees to take into account their counter-transference which has become the latest area of enquiry, these days. Rogers and his associates have made it possible for us to study the course of therapy objectively and to some extent even quantitatively. We can evalaute the change through innovative research methodology - Q-sort Stephenson's technique (Rogers 1967, Rogers and Dymond 1954, Cartwright and Lerner 1963 and critical review Wylie 1978). However, this form of psychotherapy is atheoretical. This therapy is non-directive, in the sense that it assumes that the client will find his own solution if the right conditions are offered. It implies that the therapist only needs to attend and reflect on the responses for discovering the change taking place in the client. This has been subject to considerable criticism. In the client-centered therapy the role of unconscious resistance and conflicting forces are given almost no emphasis and it makes no distinction between individual variations in the ability of reflection, intelligence, motivation etc.

3.6 Cognitive Therapy

Anxiety and depression are the most common psychological complaints observed in various medical settings. According to Goldberg and Huxley (1992) they form at least 90 percent of the illnesses in community settings, depression being the most common diagnosis. In primary care, roughly a quarter of the consultations over a year are for psychological disorders and in psychiatric clinics depression and anxiety make up over 50 percent of referrals. Their response rate to pharmacological treatment is said to be good; recovery rate is 80 percent (Blackburn 1994). This evidence of research in the West, besides our own emerging trend on Depressive illnesses (A.Venkoba Rao and others) suggests that problems faced by the treating profession are numerous:

- a substantial proportion of patients do not respond to medication.
- the problem of relapse or recurrence of illness (about 36 % of treated patients relapse within a year and despite continued medication, 34-57 % have recurrence of illness within two years follow up period).
- several patients may not be able to take medication because of concurrent physical illness or fear that such medication (in particular anxiolytics) is habit forming.
- cost of psychotropic medication over a long time can be beyond the economical resources of many.

Indeed, human suffering is manifold in chronic mental diseases, especially in Depression - which creates increased suicidal risk, loss of employment/working days etc. Costly treatment results in financial burden on the family and its dysfunctioning. Although the patient's functioning improves as depression remits, the family still experiences more dysfunction than non-clinical families (Keitner and Miller 1990). Thus a constant search for a less costly yet effective treatment is required. The cognitive therapy is a psycho-

therapeutic measure of proven efficacy and is often used as an alternative to or as an adjunct to pharmacotherapy namely, anti-depressants (Blackburn and Davidson 1990).

3.6.1 Cognitive Theory

In order to understand the rationale behind cognitive therapy, it is necessary to understand its theory. It is based upon the *model of information-processing* as developed in experimental cognitive psychology. Information processing theory uses computer as a model. It has proposed that human functioning can be best understood by taking into account how information from external sources (the environment) and from internal sources (thoughts, feelings and somatic sensations) is processed and used. Human being is seen as a system actively engaged in the selection, transformation, encoding, storage, retrieval and generation of information. In emotional disorders, such as depression, this information processing is subject to various vicissitudes and distortions.

The cognitive *structure* represents organised knowledge about oneself and the world derived from the previous experiences. Cognitive content consists of *basic beliefs and attitudes* which can increase vulnerability to depression and anxiety. The negative cognitive content or schemata towards self, world and environment - the so called *cognitive triad* - makes the self vulnerable, the environment threatening and the future unpredictable and feared. These *automatic thoughts* are triggered in reaction to external events (like stresses or hardship) or internal state (mood and feelings). They may be conscious, semiconscious or preconscious and constitute the basic data for cognitive therapy. Once the depressed mood and inconsistent behaviour have been triggered there is feedback loop mechanism, probably through the associative network in the brain which facilitates the activation of depressive anxious memories followed by more biased information processing, more depressive thought content and mood. This vicious cycle accounts for maintaining depression and anxiety. The *schemata* can be dormant which allows a period of remission; e.g., a *self-schema* - such as 'I am not lovable because I lack necessary qualities to be loved', is considered as an 'early maladaptive schema'. It is unconditional and represents highly refractory and tacit knowledge that a person has about himself. The *secondary schema,* "Life is not worth living if one is not loved" is on the other hand, conditional and allows at least the possibility of happiness, if the right conditions prevail.

Beck (1967, 1976, 1987) insists that cognitive theories are not inconsistent with biological theories. Cognitive and biological symptoms can be seen as *two sides of the same coin*. Beck sees the primacy of cognition as applying in only a subgroup of depression (unipolar non-endogeneses, reactive depression). He holds two personality factors responsible which specify the classes of stressors triggering dysfunctioning schemata viz., *sociotrophy and autonomy*. Sociotrophy is a characteristic of people who

physical illness or child birth, stressful life events - either occuring at random or as a result of the individual's personality, and coping mechanism, early childhood adversities resulting in vulnerability to adversity or loss. Once a prolonged mood of hopelessnesss and worthlessness sets in, it gives rise to depressed thinking, poor concentration, loss of interest in life and low self-esteem along with physiological disturbances in sleep, appetite, sex, bowel movements and psychomotor retardation. The clinical evidence supports the treatment plan of depression formulated by these therapists. The therapy is theory driven - a convergence between social learning theory and cognitive psychology. The growing interest in emotions by cognitive psychologists has closed the gates between the humanistic and psychoanalytic therapies (Greenberg and Safron, 1987).

In assessing the treatment needs of a depressed patient a careful analysis of the individual's behaviour and experiences (in respect of positive and negative reinforcement) is made. It involves patient's *self-monitoring* and keeping detailed records of mood fluctuations. On the basis of such analysis, a range of techniques are designed to initiate change. Cognitive therapy is not only concerned with the relations of behaviour to the outcome but with the relationship between thinking and feeling also. It teaches patients to recognize how thoughts and feelings are interlinked, both during the sessions and through patient's self-monitoring between sessions. Patients are taught to think in a focussed and rational way about their difficulties and they learn to identify destructive (catastrophic) patterns of thoughts and imagery - which operate in their minds like a running commentory or videos. Discussion with the therapist as well as self-monitoring the ruminating thoughts underlie maladaptive beliefs, such as - "I must be loved by everyone"; cognitive distortions, such as - "I am a worthless person so I should die" or exaggerate bad news or over personalise or over generalize and errors of attribution etc. Therapist helps focus the attention of the patient to these thought processes which get identified and challenged with detailed discussion. As the therapy progresses there is a shift from thought-feeling links to a concern with underlying thought contents and processes (basic assumptions) which later get replaced by a focus on initiating behavioural change. However, ways of acting and thinking require additional techniques aimed at reducing distressing symptoms by 'relaxation therapy', 'role playing', imagination and self-management technique etc.

Considering the varieties of psychopathology in depression and the fact that depressed patients are under-investigated and usually under-treated psychologically in the psychiatric setting (usually by antidepressants), the cognitive techniques require to be adopted by psychotherapists. Moreover, there is sufficient research evidence in the West that these are as effective as anti-depressant medication (Blackburn et al 1986).

The aim of psychotherapy is to modify the negative antecendents in interpersonal relationships and to understand the nature and origin of deficient personality developmental factors which are usually present in the psychi-

atric patients. The psychoanalytic literature is full of such scientific understandings like in 'ego defects'. The crucial understanding offered by psychoanalytic theory is that intra-psychic structure is interpersonally derived and hence the adult personality bears the traces of both, the early childhood learning as well as of the internalized object-relationships. Childhood traumas leave the individual with a deficient capacity for self-care and of understanding interpersonal relationships. Full treatment of psychoanalysis will be unavailable to most patient's even if provided free. Therefore, less intensive and time consuming forms of therapy may become an established practice in Indian psychiatric set up.

3.7 Length of Psychotherapeutic Treatment

The scope of brief psychotherapy is broad and several psychotherapists of various orientations have contributed to its development. This section is confined to *brief dynamic psychotherapy*, derived from psychoanalytic understanding. Since therapeutic relationship is time-limited and within well defined boundary of clinical work, the problem of therapeutic alliance of good doctor-patient relationship plays a crucial role in this therapy.

David Malan (1963, 1976, 1979) and Michael Balint (1964, 1972) in U.K., Habib Davanloo (1980) in Canada, Peter Sifneos (1972, 1979) in USA, working independently have experimented with brief psychotherapy. Towards the end of his professional life Freud had recognized that psychoanalysis could not guarantee a permanent cure. Life circumstances may lead to new problems or precipitate a relapse of a condition which had been assumed to be cured. There is a widely held assumption that long term psychotherapy is better than brief therapy. But in clinical practice we see a substantial number of patients treated with either forms of therapy return for further treatment. Bennett (1983) suggests that when in need patients find psychotherapy valuable and useful. He argues that this therapy, offered within the frame work of an enduring but latent therapeutic relationship may be more appropriate for individual developmental transitions and life events than either short or long term therapy. In theory, brief treatment should enable more patients to benefit with limited resources. This may be the reason that brief psychotherapy is seen as one of the corner stones of psychiatric practice by the National Health Services of U.K. Its wide application, in suitable cases, has been found preferable to long term treatment and capable of stimulating long term personality changes. The underlying principle of brief psychotherapy is that modification in one area of conflict can lead to an alteration of the entire internal psychodynamic system. Once a patient has gained insight through psychotherapy, his increased self-esteem in overcoming stressful life situations and negative emotions will have the potential to create and reinforce change, both from within and without (Ashurst, 1991). Freud's pupils - Sander Ferenczi and Otto Rank, published a joint work 'The development of psychoanalysis' in the year 1925. They emphasized the importance of current life events and use of 'here' and 'now' in

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transference interpretations rather than that of the historical reconstruction in therapeutic process. Rank emphasized the importance of setting a time-limit to the analytic process of separation from therapist and motivation to change. He considered them to become the central focus of psychotherapuetic work. Alexander and French (1946) emphasized that intellectual insight alone is not sufficient to bring about a change in behaviour. Only through actual emotional experience in the transference relationship the patient would learn to deal with an unbearable situation in a new way. He also advocated adaptation of newer techniques to the needs of the individual patient and hence pleaded for flexibility.

3.7.1 Scope of Brief Psychotherapy

As emphasized earlier brief therapy is *time-limited* (1 to 50 session) and *clinical work limited*. Clinical work consists of case work-up (case history and diagnostic formulation) depending on the nature of the presenting complaints, personality structure, stressful life events and situation of the patient and the approach of the therapist for crisis consultation work. The case work up may be either primarily explorative, depending upon not only the needs and capacities of the patient but also on the level of training of the psychotherapist, or it may be educative, psychoanalytic or supportive. However, the need to adhere to *here and now* situation rather than to historical reconstruction requires much activity on the part of the therapist. In particular, the therapist's conscious and realistic appraisal of the dynamic formulation of personality as well as in terms of the current stresses in his life are particularly influential in bringing about changes in the patient. The therapist's personal reaction to the patient has major implications for selection, case management and therapeutic outcome (Frances et al 1984). The common features of all forms of psychodynamic therapies are: a good therapeutic alliance between doctor and patient, emotional catharsis, interpretation given in a style leading to cognitive learning, the therapist becoming an ego-ideal, 'model' for initiation and social learning, capable of providing 'corrective emotional experience' and able to work through core-conflicts. The patient tries to solve some selected problems independently, outside the treatment situation. Therefore, the *slection of cases for brief psychotherapy is of crucial importance*. The author could see such changes following a single session of therapy, brought out in a depressed female patient.

Mrs. P., had been married happily for several years but was childless. She reported that her father died when she was a small child. Though her widowed mother brought her up nicely, got her married to an Executive Engineer, despite the fact that the patient's inner most wish was to look after her widowed mother and not get married at all. The therapist could empathize with the patient's inner mourning like a widow and her difficulties in enjoying sex life. Further probing brought out that the patient was avoiding sex with the husband and this was the reason for her not conceiving so far. The guilt feelings for 'pleasure' of any kind in the

its emphasis on training, education, attempts to objectivize and democratize the treatment process. The reader should note that in behaviour therapy intrapsychic and diagnostic classification of psychiatric diseases are put aside in favour of an overt behaviour learning scheme. The treatment programmes can be implemented without any special training being given other than the ability to follow the scientifically laid down directions. However if this were completely true there would be no man-power shortage in the field of mental health even in developed countries like U.S.A.

A combined psychobiological approach has been taken as a standard practice for all psychiatric treatment of psychotics and non-psychotics. Psychotherapy is practiced in the U.S.A. by 4500 psychiatrists, psychoanalysts, clinical psychologists and psychiatric social workers (Henry et al 1971). Yet a group of practitioners is advocating formation of a new mental health profession called *the fifth profession* (Kubie 1957, Henry et al 1971, Holt 1971, Abroms and Greenfield 1973). The spokesmen for this group want to produce a doctor of psychotherapy - an expert in the psychobiological approach to emotional problems of living. Such a psychotherapist would be different from various non-professionals or new careerists sponsored by the U.S. National Institute of Mental Health or in India by the multi-purpose worker (sponsored by National Mental Health programme for Primary Health Care envisaged during the Seventh Five Year Plan, 1986).

In order to understand the need for creating a new mental health profession, one should first consider some of the social and technological developments taking place in the Western World. One has to turn to Freud's paper - 'The question of Lay Analysis' (1926b), where he recommended creation of a new profession in psychoanalysis where one did not require any medical training but had to undergo specific psychoanalytic training. Several of his pupils rejected this advanced thinking and even now there are a few psychoanalytic training institutions in U.S.A. which do not impart psychoanalytic credentials to non-medicals. In the West, psychoanalytic psychotherapy requires patients to be highly intelligent, introspective and above all articulate in reporting fantasies, dreams and other abstractions from day to day life. They should be ready to sacrifice a lot of their time and money for frequent treatment contacts which can continue over many years. One simply cannot conceive that enough analysts could thus be trained and even if it were so, whether could they appropriately treat the bulk of psychiatrically disturbed people (Abroms and Greenfield 1973).

Freud devised a theory and treatment of mental illnesses, purely based on psychology. He looked forward to a future when psychoanalytic knowledge would be integrated into more advanced medical and biological sciences. Presumably, medically trained psychoanalysts use both, biological and psychological, means of influencing behaviours. After the death of Freud followed the *third revolution in Psychiatry* in which rapid advances were made in biological approach to mental disorders. Some of the discoveries have been quite impressive, for example, the Electrical Convulsive

Therapy (ECT) of affective disorder and psychopharmacotherapy (using anti-psychotic, anti-anxiety and mood stabilizing drugs, etc.). These led to the clinical realization that psychotherapy alone cannot treat serious mental disorders like that of Psychoses. The optimal treatment is a combination of drugs and psychotherapy, which gives better results in terms of symptom-reduction, hospital stay and discharge rate. However, a lot also depends upon the degree of psychiatric disability and family support rather than only on a single treatment approach. Biological research also had a profound effect on the mental health profession, especially in the *etiology of schizophrenia* (genetic contribution) *affective disorders* and probably in the origin of all pathological behaviours. It is no longer possible to train a mental health professional without the knowledge of biological sciences. As a consequence, the ability of non-medical therapists to provide independent and comprehensive psychiatric treatment is being questioned. In fact, it has been advocated that non-medical therapists must enter into consultative relationships with psychiatrists who should be trained in and licensed to use both biological and psychosocial methods of treatment modalities. At best the non-medicals may treat only the less disabling and milder psychiatric diseases. Even in U.S.A., Cross professional rivalries are destructively high (Abroms and Greenfield 1973).

In India many psychoanalysts, clinical psychologists, psychiatrists, social workers and nurses (not to mention the busy psychiatrists and counsellors of various sorts) have ended up by practising psychotherapy without being properly *trained and without acquiring license*. At times, some of these therapists even resort to prescribing psychoactive drugs on the plea that when a *multipurpose worker* in a village can dispense these drugs, why can't they? In most cases their psychotherapeutic techniques are seldom insight-oriented or based on the theory of personal meaning, on personality development and restructuring. More often, they are based on questionable action and techniques, hypnosis or their own version of '*Yoga*'! As elsewhere in the world quackery is mixed with science. The importance of specifying pathology, treatment and successful outcome in terms of clearly defined observable events gets overlooked. Their 'psychotherapy' practice is based on *suppressing independence and cultural value* of 'self management' through religious practice. They fail to create harmony with the self and environment by making the patient like a *Shishya* (disciple) who surrenders to the *Guru* (doctor). This model is being advocated on the untenable assumption that "since Western society and Eastern differ in their basic value systems and social dynamics, the psychotherapeutic strategies of the two must vary in accord with these patterns" (Neki 1973).

There is no doubt, that psychotherapy is still *more of an art than a science* so that its outcome is often directly related to the talent of the therapist. Psychotherapy has made several tall claims while producing fewer affective results. The efficacy of psychotherapy from a scientific point of view has not been unequivocally established (Bergin 1971, Holt 1971, Eysenck 1983).

Various modes of psychotherapy, with the exception of behaviour therapy, have fallen into a serious scientific disrepute. Critics have claimed that psychotherapy is no more than placebo-treatment (Shephered 1979) and psychoanalysis in particular is a non-scientific closed system of thought (Eysenck 1983). The details of these charges and counter charges are exhaustively documented in several books (Bloch 1982, Garfield and Bergin 1986, Luborosky 1984, Holmes and Lindley 1989).

The reader should note that the psychoanalytic approach consists primarily of a theory of meaning and that of personality development. The psychotherapeutic task consists of decoding personal and often unconscious meanings. The scientific underpinings of the psychoanalytic viewpoint lie in its account of psychological growth and development (Bowlby 1988). Interpretation in psychoanalytic therapy of personal meanings of behaviour are arrived at intuitively but not arbitrarily. Its theory of personality development is no less real than that of physical development. According to Holmes (1991), its contributions to psychiatry comprise of three distinct elements:

- speculative hypotheses about the aetiology of psychiatric disorder, i.e., the significance of early environmental influences,
- a language (metapsychology) for understanding mental life,
- a method of treatment which in some forms is of *proven effectiveness*.

The causative hypotheses for understanding mental illnesses are like adverse childhood experiences which get internalized and predispose a mental breakdown later in life (linear theory) or intrapsychic and interpersonal factors in childhood (not as causative) but producing either deviance amplification (Hoffman 1981) or resilience in the face of adversity during illness (Rutter 1987). These mean a lot in psychotherapeutic practice.

In this context, it is not enough to mention that many of us, who have been successfully helped in personal-analysis or have helped a number of patients, are a testimony to the effectiveness of psychoanalysis. The scientific responsibility requires to pay attention to the methodological problems in the process and outcome of psychotherapeutic treatment and resolve them. At the core of psychoanalyst lies the individual, with his unique personality configuration, his vulnerability to adverse psychosocial, biological and environmental factors (the bedrock on which all theorizing and psychotherapeutic practices rest).

The *Mount-Zion group* demonstrated that *hypotheses testing is possible* within psychoanalysis (Sampson and Weiss 1986). The Menninger Foundation Project (Kernberg et al 1972) has combined extensive treatment programme with concurrent research. This project is said to be a rare example of research in psychoanalysis in several ways. One must not overlook the meta-analysis of psychotherapy research findings that psyochotherapy produces positive change (Smith et al 1980). The following illustruation is

given to demonstrate how the psychodynamic understanding may have contributed to an effective outcome in a combined treatment:

Mr. C., a 48 years old lawyer, was married and lived in a nuclear family set up. His wife taught in a secondary school and they had three school going children. He described his wife as quite efficient and able to take care of the household except during periods of his frequent mental illness (bipolar depression). The support from the extended family members, especially of the emotional kind, rather than the financial, was not forthcoming as desired by Mr. C. and his wife.

Mr. C.'s frequent attacks had been treated with appropriate drugs plus lithium maintenance therapy in the past several years. During one of the hypomanic attack, in order to cut down relapse rate, he was referred for psychotherapeutic management. After a few individual sessions, and interview with his wife Mr. C. was recommended group therapy. His case history had reflected that he had psychosociol stresses, which suggested that group psychotherapy might benefit him.

He was the second among three siblings and two step-brothers. His eldest brother had emigrated to U.S.A. and the sister was married in a distant town. He had lost his mother in childhood. His father had remarried soon after the death of his first wife so that his young children could be taken care of. But Mr. C. emphasized that his grandmother took full charge of him, rather than his stepmother who was preoccupied with his stepbrothers. He described his stepbrothers as semi-literate, agriculturists, quarrelsome and who easily indulged in physical violence. Soon after their father's death, Mr. C. had to move out from the joint family as he felt the family had lost status in the community. The stepmother could not control the waywardness of her sons who resorted to alcohol and grabbed a big share of the joint property.

Mr. C. admired his father's high stature in society (Chairman of Municipal Committee) and his ability to help others. Often his relatives compared Mr. C.'s temperament and social behaviour with that of his father. He always wanted to be respected like his father and looked down upon his stepbrother's antisocial behaviour. But Mr. C. felt he had become a 'laughing stock' or a 'mental wreck' because of his generosity and helpful attitude. The extended family members often came over to settle petty quarrels on property matters and on physical violence indulged in by step brothers with the help of bad characters in the locality.

During group therapy, Mr. C. projected his sibling rivalry on a male patient, with whom he was quite friendly. Yet he even tried to throw Mr. S. out of the group by verbal assaults. He criticised and made fun of Mr. S. saying that he was extremely dependent like a child on his mother and therefore he would never be able to leave psychotherapy as he was becoming very dependent on the therapist. This negative transference in the group enabled Mr. C. to work through his pent up feelings towards his

stepbrothers as well as his own 'self-emptiness' reinforced during his childhood by the ill-treatment by his stepmother. His longing for 'good mothering' and 'real sense of value and importance' was enhanced in group interaction. Mr. C. always displayed his best behaviour, especially towards the female members of the group, who were drawn towards him because of his mature advice and pleasing manners.

Even in a hypomanic mood swing, Mr. C. resorted to humouring others rather than displaying irritability or placate other members except Mr. S. in the group. Within a short period of group psychotherapy (nearly six months) all the members felt that Mr. C. had made a good progress and recovery. By that time he was in a euthymic mood. He talked mostly of his increased satisfaction in work, in family life and improvement in general health. At that point of time, the brother settled in U.S.A. visited him and provided him the necessary support in resolving some of the joint family affairs.

However, this period was soon followed by an accident in which Mr. C. broke his leg and could not attend the group therapy for sometime. When recovered, Mr. C. rejoined the group therapy but appeared to be in mild depression. He complained of sleep disturbances and was quite apprehensive that he might have another attack of depression. At this time, the group was supportive towards him and gave him many practical tips for checking sleep disturbances and loss of overall zeal in life.

Interestingly, the group members candidly shared with Mr. C. their distaste for resorting to a sick-role under adversity. That in turn boosted his ego and was quite hopeful of his complete recovery. So he kept coming to the group regularly.

The therapist consulted his treating psychiatrist who added antidepressants to lithium. This time Mr. C.'s recovery from this depressive phase was a pleasantl surprise to him, since it was quicker than ever before.

This case illustrates that a biomedical approach which sees Affective disorders simply in terms of an illness for which appropriate drugs should be prescribed and ignores the part played by the psychodynamics or life events creating stress and strains on the individual is like ignoring the relevance of genetics factors while providing psychotherapy (when more than one members of his family gets afflicted by this Disorder).

3.9.1 Psychotherapy with Some Special Diagnostic Groups

Several claims have been made by Western Psychotherapists in an attempt to provide a comprehensive model of psychotherapy. These pertain to the effective aspects of treatment shared by diverse forms of psychotherapy, called 'change agents' (Frank 1973, Lambert 1986, Weinberger 1993 and others). Such ideas have implications for the future of psychotherapeutic

practice in Psychiatry and Medicine at large. According to Osler (Stoller 1984) "Our technology and our science are not so advanced that we can throw away art and our art not so advanced that it would collapse from whiff of science". In the DSM-III-R(APA 1987) greater weight is given to etiology, when this known and diagnostic formulation is based upon multiple dimensions (Axes). This idiographic approach comes closer to individually constructed formulation of the dynamically oriented psychotherapist who raises questions such as the following before taking on a patient for treatment:

* What the patient feels is/are his main problem(s)?
* What influences have shaped this person? How did these problems come about and influence his present state of psychopathology (psychodynamics as well as psychodiagnostic formulation)?
* What view the patient takes of himself and how he thinks others see him?
* What patterns of reactions (defense-mechanism) he adopts typically in relationship to others?
* Whether others in the patient's interpersonal relationships contribute to his problems and whether he wants them to be involved in therapy?
* Why is the patient seeking help now?

3.9.1.1 Changing Addictive Behaviour

The psychodynamic assessment as mentioned above takes a view of the patient as a whole and the therapist tries to formulate why this person, at this stage of his life, is experiencing a severe subjective disorder and behavioural maladjustment and requires professional help? In the West several studies have been carried out on addicts which have demonstrated that many people can modify problem behaviours without the benefit of formal psychotherapy (Shapiro et al 1984 and Marlatt et al 1988). Our clinical observation of patients also supports the view that they *intentionally* change their behaviour without psychotherapy. In the field of mental health there is a constant search for discovering how people change, especially seen in applications to self-inflicted addictive behaviours or sexually transmitted pathology like HIV positive/AIDS disease. Probably, the research on the basic constructs of a model that helps us to understand self-initiated and professionally assisted changes may provide us a guide line. But successful resolution of complex problems by intentional, spontaneous remission, own commitment to change or benefit by formal psychotherapy, demonstrates that not all clients suffering from addictive disorders change overnight or improve by sheer willpower. Some drop out of treatment, others relapse following a brief improvement and some even develop psychiatric co-morbidity. Research shows that inadequate motivation, resistance to therapy, defensiveness and inability to relate to others are the characteristics of such clients.

Early research work explaining the relative contributions of clients and intervention variables showed that individuals modifying addictive behaviours move through a series of stages from precontemplation to maintenance. A linear schema of these stages was discovered in research smokers attempting to quit on their own and in those professional treatment programmes (DiClemente and Prochaska 1982). Stages of change have been assessed in outpatient clients as well as self changers. These have been ascertained by two different self support methods: a discrete categorical measure which assesses the stage from a series of mutually exclusive questions (DiClemente et al 1991) and a continuous measure which yields separate Scales for precontemplation, contemplation, action and maintenance (McConnaughy et al 1983, 1989). Originally the investigators identified five stages but later reduced them to four (through principal component analysis). However, the subsequent research revealed that the fifth stage, namely preparation, should be retained. A brief description of each of the five stages according to Prochaska et al (1992) is given below :

1. Precontemplation is the stage at which there is no intention to change the behaviour in the foreseeable future. Many individuals in this stage are unaware or partially aware of their problems. As G.K. Chesterton rightly said, 'It is not that they can't see the solution. It is that they can't see the problem'. Families, friends, neighbours or employees, however, are often quite aware that the precontemplators have problems. When the addicts present themselves for psychotherapy they often do so because of pressure from others. Usually they feel coerced into changing the addictive behaviour by a spouse who threatens to leave, an employer who threatens to dismiss them, parents who threaten to disown them, or courts which threaten to punish them. They may even demonstrate change as long as the pressure is on. Once the pressure is off they often return quickly to their oid ways.

Resistance to recognizing and/or modifying the problem is a hallmark of precontemplation.

2. Contemplation is the stage in which people are aware that a problem exists and are seriously thinking about over-coming it but have not yet made a commitment to take action. People can remain stuck at the contemplation stage for long periods. Another important aspect of the contemplation stage is a weighing of the pros and cons of the problem and the proposed solution to the problem. On objective measures individuals who state that they are seriously considering changing the addictive behaviour in the next six months are classified as contemplators. Serious consideration of problem resolution is the central element of contemplation.

3. Preparation is the stage that combines intention and behavioural criteria. Individuals in this stage are intending to take action in 'the next month' and have unsuccessfully taken action in the 'past year'. As a group, individuals who are prepared for action report some small behavioural changes such as smoking five cigarettes less or delaying their first cigarette of the day for

30 minutes. Investigators prefer to conceptualize the preparation stage as the early stirrings of the action stage or the decision making process.

4. Action is the stage in which individuals modify their behaviour, experiences or environment in order to overcome their problems. Action involves overt behavioural changes and requires considerable commitment of time and energy. Modifications of the addictive behaviour made in the action stage tend to be most visible and receive the greatest external recognition. Individuals are classified in the action stage if they have successful altered the addictive behaviour. Successfully altering the addictive behaviour means reaching a particular criterion, such as abstinence over for a period extending from one day to six months.

Modification of the target behaviour to an acceptable criterion and significant overt efforts to change are the hallmarks of action.

5. Maintenance is the stage in which people work to prevent relapse and consolidate the gains attained during action. Traditionally, maintenance was viewed as a static stage. However, maintenance is continuation, not an absence of change. This stage extends from six months to an indeterminate period past the initial action. For some behaviours maintenance can be considered to last a lifetime. Being able to remain free of the addictive behaviour and being able to consistently engage in a new incompatible behaviour for more than six months are the criteria for considering someone to be in the maintenance stage. Stabilizing behaviour change and avoiding relapse are the hallmarks of maintenance.

Treatment Strategies

Prochaska et al have advocated that a person's stage of change can provide proscriptive and prescriptive information on treatment of choice. The outcome research shows that Action-Oriented-therapies are quite effective with clients who are in the preparation or action stages. But the programme has been ineffective with individuals in precontemplation or contemplation stages. However, an intensive action and maintenance oriented smoking cessation programme for Cardiac patients was highly successful for those patients in action stage and ready for action. But the same programme failed with smokers in the precontemplation and contemplation stages (Ockene et al 1988). Patients in this programme received personal counselling in the hospital and monthly telephone counselling calls for six months following hospitalization. Of the patient who began this programme in action/preparation stages, 94% were not smoking at six months follow-up. This percentage is significantly higher as compared to 66% non smoking rate of patients in similar stages who received regular care for their smoking problem. The special care programme was found to have no significant effect on patients in the precontemplation and contemplation stages. A similar mismatched stage effect was seen in another smoking programme which led these therapists to the following conclusions:

* Proper matching treatment to the client's stage of changes required, while providing psychotherapy to patients.

* The addicts recycle several times through the stages before achieving long term maintenance.

* Intervention programmes and personal expectations of people to progress linearly through the stages are likely to give disappointing and discouraging results.

* Competing systems of psychotherapy have promulgated rival processes of change. But the contradictory processes can become complementary when included in the stages of change.

* Experiential, cognitive and psychoanalytic approaches to persuasion are most useful during the precontemplation and contemplation stages.

* Behavioural and existential approaches are most useful during action and maintenance.

* People changing addictive behaviours with or without therapy can be remarkably resourceful in finding practical means of integrating the change processes.

In the Western literature, the search regarding how people intentionally modify addictive behaviour, involved thousands of participants attempting to alter their addictive behaviours like smoking or alcohol abuse and eating disorders with and without psychotherapy. In this search, the leading systems of psychotherapies seem to attempt an integration. It is said that "psychotherapy could be enhanced by the integration of the profound insights of psychoanalysis, the powerful techniques of behaviourism, the experiential methods of cognitive therapies and the liberating philosophy of existentialism. Although some psychotherapists in the West insist that such theoretical integration is philosophically impossible for ordinary people in the natural environment but can be markedly effective in finding practical means of synthesizing powerful change processes" (Prochaska et al 1992).

The prevalence of dual disorder in addictive behaviour is increasing in India as well. A hospital based study (Dube 1988) as well as surveys by others have brought out that substance abused patients have often suffered from co-psychiatric diseases. Such patients often drop out of the treatment programmes even when attended to by highly enthusiastic psychiatrists, who provide the addicts readymade treatment packages. It is evident, hence, that the traditional models of treatment for psychiatric illness as well as substance abuse are no longer adequate in responding to the reality of co-existing disorders (Ziegler-Driscoll et al 1980).

Our clinical studies also show that often the families of addicts develop a psychiatric syndrome of *Co-dependency* (Kamble et al 1993) when the burden of caring for the patient becomes unbearable. Thus, the assimilation of the addictive disorder patients suffering from a wide array of problems

and dysfunctions require an effective treatment programme. These may be run by those who, though less trained are resourceful enough in finding practical measures to integrate the changing process. This may be the reason that the effective changes are seen in those addicts who attend Alcoholics Anonymous/Drugs Anonymous/group therapy led by ex-addicts (Dube 1992). Usually addicts are concurrent abusers of alcohol, tobacco, illicit drugs and even psychotropic drugs either prescribed by their treating physician or resorted to self-medication for somatic problems. Addictive disorder was more prevalent among male youth than in females. They perceived themselves as 'hooked' after initial experimentation with such drugs. In therapy they were able to exercise self-control and gave up drugs once they could solve their existential, emotional or physical distress. However, a few hard core addicts (both males and females) were suffering from co-existing psychiatric disorders (Axis I diseases and/or personality disorders). Despite regular treatment given and follow-up by a team of psychiatrist and psychotherapists the hardcore addicts showed poor outcome. As if nothing was helping them in their emotional distress and they were unable to carry out their role obligations and responsibilities. Some were able to give up addiction for sometime, but reverted to it due to poor impulse control whenever they felt the need to search for inner peace and to be cut off from the outside world. This caused distress and disaapointment to their family members who were very unhappy seeing such frequent relapses, despite bringing the addict to the treatment regularly. These patients seemed to have a deep seated insecurity for not being understood by their family member(s) and the family members displayed a lack of faith in their recovery (even some doctors and staff members were sceptical of their recovery). There was a high rate of drop out or irregular attendance in the initial stage of psychotherapy with the hard core addicts especially soon after an episode of indiscriminate self-disclosure (Dube 1989). This type of resistance to analytical psychotherapy seems to spring from their ego defects rather than from the failure of therapeutic alliance. The hard core-addicts are hungry for love yet their heightened need for intimacy (oral-stage derivative) lacked insight and is seldom accompanied by proper judgement into the demands of reciprocal interpersonal adult bonds. This lack of ego development and defences for frustration tolerance and impulse control seem to require a long-term therapeutic regime probably a multi-modal form of treatment with proper enviornmental control that compels the hard core-addicts to resort to recycling the maladaptive behaviour.

3.9.1.2 Obesity

Like addictive disorders of drug abuse and alcohol, obesity is not a *single disorder* but a collection of disorders sharing the common symptom of increased adipose tissue accumulation and associated metabolic disturbances. Most researchers share this view, but most treatment programs accept diverse groups of obesity, without any attempt to classify the type of individual obesity. The behaviour of over-eating and under-exercise produce obesity

which is a risk factor for diabetes, gall bladder diseases, cardiovascular diseases, orthopedic problems and complications in surgery. The cause/causes of obesity are not known fully, yet as loss of weight is so specific and objectively measurable, obesity provides a challenging opportunity to test the efficacy of various forms of interventions. Like smoking, alcohol and drug addiction it is a stubborn problem. Temporary success is likely to be followed by relapse.

Obesity is the subject of control by some modification of social environment. Its incidence is much lower in high SES groups than in the lower SES groups. There is a general agreement that obesity is related to life style. A community survey in a middle class population of Delhi showed a prevalence of 36.4% obesity in females aged 40-49 years. The investigator then planned a study at the Nutrition Clinic of AIIMS (Gupta et al 1983). A large number of patients attending AIIMS for various ailments were found to have concurrent obesity; therefore, they were advised to reduce their weight as part of over all medical treatment. These patients had no Organic etiology, except an excess of weight (115% or more of the ideal weight). Each patient was subjected to assessment of socio-economic status, clinical history and examination, anthropometric measurements, dietary intake by recall method, on Zung's Depression scale and Eysenck's Personality Inventory. Results of this study showed that a good doctor-patient relationship is essential for effective outcome. The physician's instruction for increasing daily physical activity, decreasing diet intake by observing fast and adherance to dietary chart, group psychotherapy with adjunct drug therapy (given only to those who scored high on Zung's Depression scale and E.P.I.) could bring about a reduction of 2 kg. in weight (mean 5.7 ± 3.5). The rate of weight reduction was higher in those patients who continued visiting the clinic at least for five follow-ups and adhered to the treatment regime at home. Decreasing dietary intake by observing fasts being culturally acceptable was found helpful in a majority of female patients. However, those who scored high on depression and neuroticism, despite being given adjunct drug therapy did not improve in terms of weight loss in the prescribed period of five follow-ups. They did show improvement in terms of 'emotional relief' assessed on Zung's depression scale as well as on subjective report).

There are several other prescribed remedies for the treatment of obesity. The question arises: why some people continue eating even when no longer hungry? After interviewing a large number of subjects, both fat and thin, Schachter concluded that people with normal weight eat with their bodily sensation of hunger, which is related to physiological variables. Whereas, obese eat with external cues like: time of the day and availability of food in terms of its quality and quantity etc. According to this point of view the only way to control hunger in the obese is to keep the food away, which is practically impossible. On the other hand, people who exercise extreme voluntary dietary control suffer from another abnormality of eating disorder called 'Anorexia nervosa'. There is a rapid loss of weight in these patients. This is generally seen in body-image conscious adolescent females.

3.9.1.3 Psychotherapy for Socially Disadvantaged Youth

Psychotherapy in the western world is an institutionalized occasion for deprived persons to obtain genuine care, empathy and non-possessive warmth from a trained psychotherapist who, in principle, subscribes to the view of encouraging the socially disadvantaged person to find his own answers to his problems of living. In developing countries like ours though provision for counselling is not readily available, yet, some incentives for acquiring professional education are given. But when such youth come for higher education it seems that social and environmental factors come in the way of their academic success. The psychoanalytic concept of Ego-identity (Erikson 1963) denotes an individual's views on his ideals and standards, his behaviour and role in the society in which he lives. It is a comprehensive gain which the individual at the end of adolescence must have derived from all his preadult experiences in order to be ready for the task of adulthood. The problems of social adjustment of these students in higher education at the Indian Universities need scientific enquiry. There is enough plausibility of effectively handling these issues within the framework of Erikson's stages of personality development. While there have been demands for establishing some more counselling centres for university students, no attempt has been made to evolve the model of appropriate service, especially, for the socially disadvantaged students.

The socially disadvantaged persons in India are not only those who have been economically deprived in childhood or at other critical stages of development but also those who have suffered other types of 'deprivations'. The term stands for *a variety of situations* like insufficient contact with other human beings, cultural deprivation, stimulus deprivation, economic deprivation and sequelae of malnutrition etc., or a combination of different proportions of all these in any given case (Nagara 1972). Any attempt to measure social deprivation should tap as many areas as possible and include all possible aspects of experiential inputs an individual has received (Tripathi and Misra, 1975). The influence of early childhood experiences in shaping personality and latter adult behaviour are the basic assumptions in the psychoanalytic theory of pesonality development.

Some *research evidence* has indicated that insecurity, lack of future orientation, rigidity, a high degree of anxiety and slightly lower self-image are psychosocial attributes of the socially disadvantaged (Dube and Sachdev 1983). On the other hand, Ramalingaswami et al (1972) found that medical students ensured of lucrative profession were concerned about their personal economic situation (51%), about their job (48%) and then with good domestic life (33%). In his study, Cantril (1963) also found that 70% Indians express concern about economic situation, 39% about family and 22% about job or work situation. Several social scientists have raised the issue that mere membership in the scheduled castes (SC) and scheduled tribes (ST) should not justify inclusion within the concept of socially 'disadvan-

taged' and emphasized that the definition of 'disadvantaged' grants should be based upon a refined assessment of all relevant environmental factors plus the subjective response of vulnerability in the persons afflicted.

Some studies show that effects of disadvantages are not always adverse (Misra 1978, Dash 1980, Rath, Dash and Dash 1979). The existing studies do not provide unambiguous data but suggest the possibility that disadvantaged groups are different rather than deficient. One potential source of difference is motivation (Misra 1983). The preliminary findings have shown that first generation learners' initial interaction with university was characterized by a variety of problems. They perceive the environment less positively and faced difficulties in dealing with demands of university life. Their effective reactions are negative and coping strategies were largely non-task oriented.

The behaviour exhibited by persons in some form of distress has the quality of a message. Several studies in the West have been carried out to verify the findings of Social psychiatry on the effect of the immediate environment on the onset of disorder, their impact on the course of neurotic disorders as well as on the interaction between social environment and psychological attributes of the individual. The 'Social bond' hypothesis that deficiency in social relationship is one of the causal factors in the onset of neurosis especially when the individual is exposed to high level of adversity in childhood. Some of the phenomenology of alienation, student unrest, drug abuse, para-suicidal attempts or morbid forms of neurotic disorders in university students can be construed as morbid variants of a behaviour category called 'care eliciting response' (Henderson 1974). Although their later studies point to the importance of long term constitutional factors in the etiology of neurosis (Henderson et al 1981).

The concept of 'modernity' has emerged as crucial in the study of social change and development in India and has a measuring scale for its study (Singh 1984). During the period of rapid social and historical changes, attitudes take on a new meaning and quickly becomes differentiated from traditional patterns of experience. As these new patterns of experience consolidate they may give rise to unique generational styles. Such differences seem to be more of *socio-cultural issues* than of personality structure (Halyal 1984). However, these are bound to create 'generation gap' in the University youth.

In the recent years, the world has seen a wave of Student-insurgency, as the students have taken a radical stand on the vexing problems. But this international picture of student revolt is a complex one. Any naive attempt to apply the experiences of one region to another, only lead to confusion (Halliday 1969). However, it presages a renewal of *revolutionary politics*, since student insurgents have rejected established models of political action. The struggle generally is against the social system as a whole; they refuse to participate in it and like to experiment on their own (Cockburn 1969).

Treatment Strategies

Student Counselling should focus on the effects of immediate social environment and early childhood experiences at the onset, on the course of 'identity crisis' in the youth at the university level and with the additional help while providing the treatment of short-term psychoanalytically oriented psychotherapy without charging any fee as a social support system for enabling them to work through their 'ego-identity' problems. In helping the Socially-disadvantaged youth, by establishing these counseling centres for providing the individual based psychotherapy, the following three objectives should be kept in mind:

1. An attempt should be made to increase the psychosocial adaptiveness of the socially disadvantged by strengthening institutions and agencies which are directly involved in looking after their welfare, for example, family, school, employment place, health centres, etc.

2. The social support system network should be enlarged to and fill the lacunae in the traditional institutions. The youth should be encouraged to pose their problems to the counsellers and seek timely help about how to approach voluntary welfare agencies, such as educationists, legal experts, administrators, agricultural workers and/or primary health workers. The *social support system* should not only provide help to the socially disadvantaged but also encourage them to view their personal needs in the context of the totality of problems of their community. The mental health value of the 'greatest good for the greatest number' should be promoted.

3. Efforts should be made to organise the socially disadvantaged as a *resourceful community* who can guard themselves against social stress and caused by social apathy. They require long-term special protection like reservations of seats, police protection, etc. to deal with these stresses. Like any other citizen when in need, they should get the support of the hospitals, administrator or law. The welfare state should give top most priority to the needs of this most vulnerable section of the society.

3.9.1.4 Borderline Personality Disorders (BPD)

Stern (1938) was the first to use the term 'borderline'. But the real parentage of this term has been attributed to 'As if personality' of Deutsch (1942); the 'Ambulatory Schizophrenia' of Zilboorg (1941), 'Latent Schizophrenia' of Rorschach (1921). It is said that Knight's paper has popularized the term 'borderline'. There are several other names like 'Preschizophrenia', 'Schizoid/Schizophrenic' character, 'Occult-Schizophrenia'. However, the most popular nomenclature is the term 'Pseudoneurotic-Schizophrenia' defined by Hoch and Polatin (1949) as a specific psychopathological condition characterized by the combination of Pan-neurosis, Pan-anxiety, Pan-sexuality together with symptoms of Schizophrenia. Though the usage of the

term 'Borderline patients' has become common a disagreement over its definition has not been resolved. Till BPD was classified in the DSM-III under Axis II - which subsumes both developmental disorders and personality disorders. In view of the *multi-axial approach* of the DSM III, the BPD patients may also develop an illness classified under Axis I such as Schizophrenia or affective disorder. The uncertainty in the usage of this term in the Indian setting may subside in future and BPD may be viewed under personality disorders. However, the reader should note that in the psychiatric literature BPD has a historical background of multiple/changing diagnosis, which led to its being conceptualized differently. According to Bateman (1991) it could be classified into the following:

- a specific category of personality disorder
- a general category of personality disorder
- a variant of affective disorders
- diagnosis based upon psychoanalytic criteria

In the *Indian Psychiatric set-up* the label -'Borderline patient' - was assigned more often, when a clinician was uncertain about the diagnosis of a patient or when a patient appeared to have both neurotic and psychotic features, or a state of normalcy with transient psychotic-breakdown. In its linguistic sense the term 'borderline' conveys a mid-level of severity or intermediary degree of either personality functioning (Millon 1969) or structural Organization (Kernberg 1967, 1970) but Indian clinicians seem to agree with Knight (1953) who called the borderline patient a 'waste basket diagnosis' probably because personality-axis diagnosis are not popular except of 'Anti-social personality'(Dube 1983).

Treatment Strategies

The most commonly recommended form of treatment of BPD is psychoanalytic psychotherapy. Some authors have proposed that pharmacological treatment of BPD with antidepressants is also effective since co-existance of affective illness is far greater than the incidence of each disorder alone (Gunderson and Elliot 1985). However, there is no convincing evidence that this is the case, although anti-psychotic medication has been shown to be of some benefit (Soloff et al 1986).

Among the salient characteristics of borderline patients as described in psychoanalytic literature are: "a predominance of the 'Psychotic part of the personality', intolerance of frustration, preponderance of aggressive impulses, utilization of pathological splitting, narcissistic identifications, fantasies of omnipotence and omniscience and idealization as central defence processes identity disturbances, states of diffused anxiety defective contact with reality though without complete loss of touch with it, temporary loss of control over impulses with a tendency towards acting out, predominance of primitive object-relations, depression and extreme infantile dependence

Atharvaveda composed between 1800-8000 BC. The ultimate aim of the *traditional Indian medicine* is not just physical health but salvation (*Nirvana*). The four-fold objectives of various stages of human growth (*Ashrams*) are specified as *Brahmacharya, Grihastha, Vanprastha and Sanyasa*. The first *brahmacharya* is the stage of development of body and mind through acquisition of knowledge, robust health and impulse control. *Grihastha* is the next phase of development requiring the individual to fulfill his obligations by leading a family life and engaging in activities supportive of the goals of the stage through acquisition of property, wealth etc. The *vanprastha* stage of development enjoins on him slowly to start withdrawing himself from his attachments having fulfilled his obligations to family and security by engaging in activities which are worthwhile in themselves and which do not demand reciprocity from others. Finally *sanyasa,* the last phase of human development wherein one is called upon to practise detachment from the world of objects and people as a preparation for the inevitable, as Freud put it: "Death is not necessary, but inevitable". Psychologically as ego evolved from birth, it must dissolve itself by surrendering its attachments, since (empirical) selfhood and its nexus are the cause of pain and suffering.

The Indian philosophical system of *Sankhya* proceeds further to analyse the nature of suffering (*Adibhautika, Adhyatmika* and *Adidaivika)* and its resolution through discriminative knowledge of the nature of intellect, selfhood (*Ahamkara*), mind and consciousness.

Corresponding to but overlapping are the four-fold desired goals at various stages of human existence: *Dharma* (duty), *Artha* (Wealth), *Kama* (desire) and ultimately *Moksha* (Salvation). They represent the performance of ones obligations *(Dharma,* wrongly translated as religion), the acquisition of property and regulation *(Artha* and *Kama)* for discharging social obligation and then moving on to activities promoting self-fulfillment *Moksha*. Within its parameters, this traditional Indian medical view seems to be in line with the *WHO definition of 'health'* which has viewed health as an issue not just of the body but also of the mind. Yoga recognises the relevance of treating body, mind, and soul and brings this discipline in daily life. It has offered a complete health education. Yoga endows us with the physical capacity to become aware of non-physical, spiritual aspects of our existence.

Yoga practised on a daily basis produces relaxation of body and mind, helps to turn the mind within and in its expansion. It requires a long conditioning process and gradual evolution of a *sadhaka* (practitioner) that fosters the ability to restrain his impulses and regulate his desires to achieve inner mastery. But when one is affilicted with mental anguish and distress one cannot practice yoga. However, the simple technique of 'Transcendental Meditation' (TM) has come to the rescue. It disposes off all the other prerequisites of yoga and concentrates only on meditation. The procedure of TM is simple and standardised. Teachers trained in TM have initiated millions of people all over the world. As the number of the meditators is large

and willing to volunteer for research, several research claims have been published in scientific journals. However, the pioneering work of Wallace et al (1971), Benson et al (1973) on 20 minutes of daily practice of TM has provided a scientific window to *yoga* in the West. TM is also called a science of creative intelligence.

Bio-feedback (the *Western form of Yoga)* is also being widely scientifically studied. Its *instrumention* (e.g., Finger-temperature thermometer) bridges the communication gap between involuntary processes and their conscious recognition and control. This is achieved through monitoring and analysis of the ongoing response patterns of specific physiological functions (like brain waves, muscle function, heart rate, skin temperature etc). This information is then conveyed to the individual by generating the signal on the bio-feedback instruments. It is a typical learning situation which rquires a conscious control of involuntary physiological functions. In collaboration with visiting scientists from the Menninger Foundation of USA (see appendix) the author carried out *Bio-feedback training* on patients attending the psychiatry department of AIIMS. In the psychotherapeutic setting biofeed back training was found effective in reducing the psychosomatic tension rapidly but required supplement psychotherapy for emotional and interpersonal problems. Now-a-days various preventive as well as curative measures of yoga are being applied. Some psychotherapists have reported meditative practices showing good results even with psychiatric patients (Goleman 1971, Vahia et al 1974, Neki 1975a, Scharfetter 1979 and others).

The philosophy of *yoga* was defined as 'Practical Vedanta' by Swami Vivekanand during his visit to the West, nearly a century ago. *Yoga* has a place in the contemporary living as we are vulnerable to tensions and diseases related to the environmental stressors. In the era of rapidly changing values and life styles in urban cities, one is constantly exposed to the various types of pollution while enduring the daily maze of the rat race of the city life. There is emotional isolation due to the break-up of the joint family, the necessity of the nuclear family to double-income, the inevitable shifts in the male and the female gender roles that have adversely affected our child-rearing practices and care of the elders. The pressures of overpopulation, poverty, crime rate and drug addiction all seem to take their toll on our psychological and mental health. There is incredible competitivenss in all walks of life and even the school going children are not spared. Although human body is equipped with inner shock absorbers and adapts itself while dealing with tensions and can to some extent change its environment according to its needs, yet, severe and prolonged exposure to stress-producing situations often make unbearable demands on human body and mind causing diseases.

Mental illness is a term taken to mean insanity in the severest of its form and most of us feel that we should not be concerned with such extreme forms of mental illnesses. But the pressure on body and mind manifest themselves in numerous 'behavioural symptoms' - like headache, fatigue,

aggression, depression, anxiety, high blood pressure, heart attack, ulcers etc. We have to take on the difficult task of adjusting to the fast pace of social structure in our changing society. It seems as if we are getting used to planning and worrying to the extent that many of us cultivate the habit of restlessness. It even seems abnormal to allow the body to relax and the mind to become quiet! There are many inventories of the strain producing life events (Holmes and Rahe 1967, Dube et al 1994) and their stress management packages. Despite preventive mental health programs and mental hygiene movements, millions of people all over the world become victims to suicidal deaths; which is often a desparate cry for help.

The Existential psychologists have emphasised that spiritual conflict and distress are at the root of most of the problems of our times. The therapeutic systems of our times cannot afford to ignore the spiritual dimension. There is an innate yearning to expand our awareness, to understand the nature of our universe and to know who and what we really are. The most profound knowledge about the nature of reality comes through intution rather than logic, from the superaconscious rather than the conscious mind. Jung (1933) recognised this long back and wrote that he was able to cure those mid-life patients who required a spiritual orientation of life. Transpersonal psychologists (A.Maslow, K.Wilber, F.Vaughan) have called attention to this important yet neglected area in modern psychology. A factor-analytic study (Zainuddin 1993) carried out on two hundred and twenty university teachers on the relationship between the needs and spirituality orientation found the two needs of Autonomy and Aggression (Factor I) to be the best negative predictors of spirituality. Man cannot attain his goal without practising the higher principles of life.

3.9.3 Critical Discussion

According to the WHO manifesto, 'Health is a fundamental right'. India also subscribes to its ideal of health for all by 2000 A.D. Yet, a large majority of our people are poor, illiterate, and unemployed. They cannot afford the costly medical treatment and so the onus falls on our welfare state. No system of medicine is an island entirely by itself; it has to draw concepts and techniques from other systems of medicine and other disciplines. In this great pursuit of health for all the barrier between one system of medicine and the other has to disappear. As also the one between the ancient (Yoga) and the modern (Allopathic medicine). The great *Ayurvedic* teacher, *Charka* proclaimed, "There is no limit to the science and knowledge of medicine".*

There are *sociological and economic reasons* behind the current day *emerging trends* in the practice of psychiatry and Psychotherapy. A purely medico-biological approach is *no longer acceptable. Patients need and ask for treatment of interpersonal problems and stresses of modern living,* which psychomedical methods of treatment can provide. Another important change at present is the thrust on *community psychiatry* and on strength-

*This quotation is from his famous treatise *'Charaka Samhita'*, written about 200 A.D.

ening the family support system in the treatment of mental illness rather than on hospital based indoor (mental hospital) or even on outdoor care. This emphasis has considerably broadened the scope of work for other mental health workers rather than restrict it to the psychiatrist alone. However, demand for psychological methods of treatment with limited trained manpower has led to the search for brief forms of psychotherapy, shorter training programs for therapist's and scientific evaluation of comparable efficacy of those techniques to bring quick and cost-effective outcomes (Durham et al 1994). Although the debate between the diverse claims of major schools of psychotherapies have not been resolved, yet, there is an attempt to define psychotherapy in general terms; thus encompasses a great variety of approaches. According to Holmes (1991), "Psychotherapy is a form of treatment based on the systematic use of a relationship between a therapist and patient, as opposed to pharmacological and social methods, to produce changes in cognition, feelings and behaviour".

There are attempts to provide *newer techniques* of psychotherapy *combining the diverse approaches*: the theoretical concepts of behavioural therapy, cognitive therapy and analytical therapy (Ryle 1990). Eclecticism (Paul's matrix) - in which psychotherapeutic intervention is matched with patient's needs, in terms of both illness and personality has been advocated. This theoretical argument is being supported by empirical studies in the West. However, in the context of providing psychotherapy in India, the author feels that one should first learn one technique of psychotherapy, under proper supervision. After gathering clinical-cum-research experience for supporting or rejecting the exploratory hypotheses, one shoulddecide to combine the diverse approaches in terms of the patient's needs and the requirements of the clinical setting.

Reader may find Table IV useful in application of psychoanalytic theory and practice in the changing scene of psychotherapy:

Table IV : Emerging Trends in The Psychoanalytic Therapy and practice

Theory	Technique	Mode	Setting	Timing	Level
Intrapsychic personality formulations - based on Psychoanalytic concepts- a Bio-Psycho-Social model with interacting environmental & stressful life events, factors affecting individual adaptability and vulnerability to a disease process	**Self help** Psycho-educational with ways of Yogic/ belief-systems of one's cultural modes of style of living in harmony with outside world. **Counselling** Mental Health workers Psychotherapy by non-specialist **Psychoanalysis** & allied forms of therapies	Individual Group Couple Family Community Consultation	Walk-in-clinic Out patient Indoor Private Practice Community at large	**Duration** Very brief Brief (<6 months) Long term Time limited (2-5 years) Indefinite **Frequency** Once a week Twice a week Thrice a week	**Self help*** **Level I**** Counselling by ex-patients even **Level II***** Nonspecialist Psychotherapy by Mental Health workers **Level III***** Specialist-Psychoanalytic Psychotherapy

* Self help - Psycho-educational packages to be prepared & ex-patients, NGO & volunteers to impart therapy
** Level I - Orientation training of psychotherapy & mental health-workers
*** Level II & III - Specialized psychotherapy training provided by accredited institu tion

GLOSSARY

AMBIVALENCE: Describes the simultaneous existence of opposite feelings, attitudes and tendencies directed towards another person, thing or situation. In this most general sense, ambivalence is universal and not significant because there are very few affectionate relations which are uncomplicated by some hostility and many hostile relations are tempered by affection. When, however, the strength of these conflicting feelings increases to the point where action seems unavoidable yet inacceptable, some defensive maneuver is undertaken which often leads directly to mental illness. Under these circumstances, the ambivalence is repressed, that is, only some of the two sets of feelings are permitted to become conscious. Usually it is the hostility which is repressed, but sometimes it is the affection. Successful psychoanalytic detection of the repressed component of the ambivalence, and its successful demonstration to the patient, will usually exert a therapeutic influence.

ANIMA: In Jungian psychology, the inner being of an individual as opposed to the outer character or persona that he presents to the world. Further, the anima may be the more feminine 'soul' or inner self of a man; the animus the more masculine soul of a woman. See also Jung.

BEATING FANTASY: A special form of fantasy arising in childhood, but often encountered in adult patients. Classically, it has a tripartite form: the earliest version consists of conscious imagining that a sibling is being beaten by father; a second version, that the person himself (or herself) is being beaten by father, remains unconscious; while the final version, a conscious one, conceives of someone being beaten by an authority figure. The last fantasy often accompanies childhood masturbatory activities. There is evidence to suggest that some form of this fantasy occurs in the course of everyone's development, but only in certain circumstances does it have a profound effect on later development. Various defenses may be established against the imagined implications of the fantasies, which may result in symptoms, character changes of a masochistic nature, or in actual sadomasochistic sexual practices.

BISEXUALITY: Presence of the qualities of both sexes in the same individual. In psychoanalytic theory considered to be a universal trait, so that each individual has both masculine and feminine traits and homosexual and heterosexual tendencies, latent if not overt.

BODY EGO: The core of the ego, which consists of the psychic representation of the surface of the body. At the time the term originated, the structural theory had not yet been formulated, and ego was synonymous with what is now called 'the self', although it also had connotations of a system of the psychic apparatus governing certain functions. 'Body ego' retains this undifferentiated double meaning, since there is evi-

dence to support the hypothesis is that, developmentally, ego functioning is based on the model of body function, i.e., the mind introjects - takes in, as in nursing - what is need-satisfying and pleasurable, and seeks to evacuate what is noxious or unpleasant. The 'body ego' therefore also refers to this primitive type of ego functioning.

BODY IMAGE: The mental representation of one's body at any moment. The ego constructs it from the visual perception and tactile exploration of the surface of one's body and sensations from the inner organs, skeleto-muscular system, and the skin. Depending on the person's instinctual or defensive needs, the body image at any time may be realistic or unrealistic. For example, a woman's body image may include an 'illusory penis' under the influence of her masculine wishes. See penis envy.

BORDERLINE STATE: A descriptive term referring to a group of conditions which manifest both neurotic and psychotic phenomena without fitting unequivocally into either diagnostic category. In many borderline states, neurotic sym-ptoms of a hysterical, phobic, or obsessive-compulsive nature are observed and represent defenses against more regressive and primitive states. Some of these conditions have been called 'pseudoneurotic schizophrenia'. In borderline states, superficial adaptation to the environment and the ability to maintain object relations may be relatively intact; hence many ego functions are fairly well preserved. Yet there is a weakness in the defenses against primitive instinctual impulses and interference with the overall evaluation of reality, logical thinking, adaptation to the environment, and other aspects of ego functioning. Under stress the psychotic aspects may come to the fore, since the flexibility and adaptability of these patients are reduced. Patients of this nature often fail to recognize their difficulties as symptoms, and have no significant wish for help except on an emergency basis.

CASTRATION ANXIETY: See anxiety. The very great importance of castration anxiety (fear of genital loss or injury) was an early and unexpected discovery in the history of psychoanalysis. It is an integral part of the oedipus complex, and is a major source of conflict in the course of childhood development. As part of the oedipus complex it plays a large role both in neurotic symptoms in later life and in the formation of character traits, whether normal or abnormal. In adults the fear has usually been displaced from the genitals to other parts of the body, so that exaggerated fear of injury to any part is based to some degree on castration anxiety or its feminine counterpart: fear of penetration.

CATHARSIS: Refers to a technical procedure to facilitate the expression of emotion which the patient; has either repressed or suppressed. In the early days of psychoanalysis it was considered of primary importance as a therapeutic method, but now its role has become secondary as the importance of insight and working through has gained recognition.

CATHEXIS: A term derived from the Greek 'Catechein, to occupy' by the translators of Freud for the German word 'Besetzung'. The dynamic nature of human psychic activity in adaptation and in conflict, with forces working together or in opposition, calls for a theory of energies. The theory assumes a psychic energy (which is not the same as physical energy) derived from biological needs and manifested in wishes and impulses. On the basis of this theory, human behaviour, thought, and emotion are the resultant of the interaction of the basic impulses and the counter-action of the controlling functions of the psyche. The basic impulses are represented in the theory as 'drives' (German: Trieb) and classified as libidinal and aggressive. The term 'cathexis' denotes the investment of the psychic energy of a drive in a mental representation. The latter may be an image, a symbol, a fantasy, an idea of a concept and these, in turn, may be conscious or unconscious. Thus when we say that 'A cathects B' we mean that subject A invests in his mental representation of B the energies of his libidinal or aggressive drives. What would be observed would be fantasies of love or hate directed by A toward B.

CHARACTER: That aspect of personality (the image of person and his ways of reacting perceived by others) which reflects the individual's habitual modes of bring-

ing into harmony his own inner needs and the demands of the external world. It is a constellation of relatively stable and constant ways of reconciling conflicts between the various parts of the psychic apparatus to achieve adjustment in relation to the environment. Character therefore has a permanent quality that affects the degree and manner of drive discharge, defenses, affects, specific object relationships, and adaptive functioning in general. Although both neurotic symptoms and character traits are compromises between instinctual impulses and forces of the ego that try to direct and organize an appropriate gratification, or to postpone or block the impulses in response to restraining or inhibiting forces, symptoms do not fit into the customary mode of behaviour and are experienced as alien to the character, i.e., they are ego-dystonic not accepted as part of the self.

The integrating, synthesizing and organizing functions of the ego are significantly involved in determining character. Through these functions stimuli and impulses are sifted and organized. Some are permitted to find expression directly while others are tolerated only in altered form. Permanent character traits are either perpetuations of original impulses in modified form, sublimations of them, or reaction formations against them. Thus, some character attitudes or traits are defenses, others are not, but none are completely independent of instinctual conflicts. Certain character attitudes, which appear to be instinctual nevertheless serve a defensive function; and the defenses are instituted not only against id impulses, but against affects, especially anxiety, and even against the defenses themselves. Whether character traits are healthy or pathological is not dependent on the instinctual gratification permitted or on the defenses against such gratification, but on the ego's capacity to achieve a degree of flexibility, mobility, and even reversibility within a framework of constancy, which will lead to optimal mental functioning.

Some character traits are specifically correlated with the phase of libidinal development associated with the erogenous zones. See orality, anality, Ambition and shame are often associated with urethral erotism. Recklessness resoluteness.

COUNTER TRANSFERENCE: Refers to the attitudes and feelings, only partly conscious, of the analyst towards the patient. These may reflect the analyst's own unconscious conflicts, and if he is not constantly aware of this, may affect his understanding and therapeutic handling of the patient. In counter transference, the analyst has displaced on to the patient attitudes and feelings derived from earlier situations in his own life; the process is analogous to transference, the patient's similar reaction to the analyst, an important instrument in analytic therapy. One of the cardinal purposes of the analyst's own analysis during his training is to make him aware of his own conflicts and their derivatives, so that they do not distort his therapeutic work with patients. The analyst's continuing scrutiny of his own counter transference feelings frequently provides correct clues to the meaning of the patient's behaviour, feelings, and thoughts, and may facilitate more prompt perception of the patient's unconscious.

CONTRAINDICATIONS FOR ANALYSIS: Those features of the clinical picture of a patient, and of his basic personality pattern and total life situation, which tend to militate against the likelihood of successful utilization of analysis at a specific time. Any condition which would prevent or seriously interfere with the practical application of analysis would be a contraindication - for example, physical incapacitation sufficient to prevent attendance at sessions, the presence of medical, surgical or other problems requiring urgent attention, etc. In addition, certain trends which are part of a prospective patient's neurosis or character may tend to block or disrupt analysis, if present in sufficient number or intensity. Examples here would be strong self-punitive tendencies, uncontrollable impulsiveness, pathological lying, extreme anxiety or any undiminishable resistance to being in treatment.

CONVERSION: A complex psychopathological process which attempts to conceptualize the rather poorly understood "leap from the mind to the body". Historically it has been intimately and almost exclusively linked with symptom formation in hysteria.

Originally it was understood by Freud as "the transformation of psychic excitement into the chronic physical symptoms which characterize hysteria". More specifically, it represents the regressive process by which unconscious mental representations (especially thoughts and fantasies) bring about somatic changes or dysfunctions in order to express in a distorted way the derivatives of repressed forbidden impulses as modified by the individual's defenses. These somatic changes expressed in symbolic body language (q.v. hysteria, symbolism, symptom formation) represent a compromise and composite of the forbidden libidinal and aggressive impulses and the defensive forces which bring about the distortion. Conversion is therefore part of an unconscious process leading toward hysterical symptom formation in which there is a predominantly phallic exhibitionistic orientation, rooted in conflicts derived from the oedipal phase and centered around the problem of castration anxiety. In addition, it has been generally accepted (although recently challenged) that conversion symptoms occur almost exclusively in organs and functions under the control of the voluntary nervous and muscular systems (as contrasted with the involuntary muscular and autonomic nervous systems).

Conversion symptoms are not simply somatic expressions of affects, but are specific representations of unconscious thoughts and fantasies which can be uncovered and retranslated through analysis from their 'somatic language' into their original word language; this 'translation' has shown that the meaning of each conversion symptom is unique for every individual.

The recent broadening of the concept of conversion by F. Deutsch and L. Rangell suggests that conversion, as an active ego process, can occur through-out the entire range of psychopathology at any stage of libidinal and ego development. Max Schur has recently made another important linkage of conversion to the concepts of somatization and desomatization.

CRITERIA FOR ANALYSIS: Those features, noted under indications and contraindications for analysis, the assessment of which, on balance, determine the advisability of analysis as the treatment choice for a particular patient at a particular time. Sometimes used as synonymous with indications for analysis.

DEFENSE MECHANISMS: Defense is general term used to describe the struggles of the ego to protect itself against danger. The danger arises because of the threat of eruption into consciousness of a repressed wish which has become associated with some real or imagined punishment. This is signalled by painful feelings of anxiety or guilt, and these feelings impel the ego to ward off the wish or drive. Defense always operates unconsciously so that the person is unaware of what is taking place. The specific methods of warding off such dangerous drives or wishes are known as defense mechanisms. The operation of these mechanisms may result in a deletion or distortion of some aspect of reality. The following are examples of a few defense mechanisms and how they operate:

1) Repression - consists of the expelling and withholding from conscious awareness of an idea or feeling. It may operate either by excluding from awareness what was once experienced on a conscious level or it may curb ideas and feelings before they have reached consciousness, so that they never become conscious except as a result of analysis; thus a person can be unaware of feelings of hatred directed at a parent or sibling. Possible at any time during life, repression regularly occurs in respect to childhood events during the crucial period before six years of age (infantile amnesia).

2) Displacement - Repression may be bolstered and made secure by the investment of the repressed feelings in a substitute object. Thus a son who has repressed his hatred for his father may experience hostile feelings against other male authority figures.

3) Reaction Formation - also ensures the efficient maintenance of repression. It consists of the replacement in conscious awareness of a painful idea or feeling by its opposite. Thus a child who has repressed feelings of hate toward the mother may develop an extreme solicitousness and concern for her welfare.

4) Projection - is a process whereby a painful impulse or idea is attributed to the external world. The ideas or feelings which the person cannot tolerate in himself may undergo

a transformation before they are projected, as in the case of paranoid projections which Freud recognized as being based on unconscious homosexuality. First, the feeling of love is transformed into hatred, and then the hatred projected into the person who was the object of the unacceptable homosexual love. That person is then taken to be the persecutor, and the patient is the object of his hate.

5) Compensation - focus on positive fantasy used in the management of depression and narcissistic interests to alleviate depression and inflate self-esteem.

6) Denial - distortion of aspects of reality used in the management of hysteric and otherwise expressive personalities by screening out negative information.

7) Displacement - shifting reactions from appropriate targets to less threatening figures. Utilized by passive aggressive and dependent personalities to manager anger and hostility by expressing such feelings indirectly.

8) Intellectualization - emphasis and exaggeration of thoughts over feelings to achieve a dispassionate, objective stance. Obsessional or compulsive types also utilize isolation, rationalisation, sublimation, and undoing in addition to intellectualization in order to fortify a sense of control over the environment.

9) Isolation - ideas are kept separate from any connecting feelings. This defense is seen in obsessional and compulsive disorders.

10) Rationalization - uniquitous, although prominent in obsessional disorders.

11) Reaction Formation - the emotions of attraction and pleasure are reversed. For example, sexual feelings are turned into revulsion, or hostility into solicitousness because of the threatening nature of the pleasure that would otherwise be experienced. One of the defenses utilized in manic states.

12) Sublimation - pleasure is transformed into work energy, as frequently seen in obsessional and manic states.

13) Regression - reliance on behaviours mastered earlier in development (Observed in the psychopathic motoric style).

14) Repression - expulsion of threatening material from consciousness. Germane to all defenses, repression sustains the unconscious amalgam of memories and feelings, and is used extensively by passive, schizoid, and hysteric personalities.

15) Undoing - designed to sustain a position of balance by canceling threatening material, undoing is seen in obsessive and compulsive states.

16) Splitting - contains elements of denial and displacement so that other figures can be seen as purely good or purely bad without a sense of contradictions; or a single figure can be seen at different times in ideal or devalued terms without an awareness of contradiction.

17) Turning Against the Self - hostility is more tolerable toward the self than toward another person, as seen in depression.

Typical Diagnosis - Defense Correspondence

Diagnosis	Defense
Hysteric	Denial, repression
Obsessive-Aggressive	Intellectualization, isolation, undoing, rationalization, sublimation
Passive-Aggressive	Displacement
Depression	Compensation, turning against themselves
Narcissistic disturbance	Compensation
Paranoid	Projection
Borderline	Splitting
Psychopathic	Regression
Manic	Reaction formation, compensation, sublimation

There are several other defense mechanisms for which the reader should consult the text books of psychiatry. However, the conceptualisation of the ego mechanism of defense remains one of the most valuable contributions that psychoanalysis has made to Medicine. Valliant (1971) proposed a theoretical hierarchial organisation of adaptive ego mechanism that correlates highly with degree of mental illness. For example:

Group I - Narcissistic Defenses viz. Delusional Projection, Denial (Psychotic), Distortion.
Group II - Immature defenses - Projection, Hypochondriasis, Passive-Aggressive behaviour, Acting-out.
Group III - Neurotic Defenses - Intellectualization, Repression, Displacement, Reaction Formation, Dissociation.
Group IV - Mature Defenses - Altruism, Humor, Suppression, Anticipation, Sublination.

Nature of control mechanisms: Control mechanisms are derived from ego and superego functions. Controls include cognitive, intellectual, ego, superego, individual defense mechanisms, character traits, fantasy, and phobic reactions. The types of controls are:

Cognitive controls. Concentration, attention and consistent functioning are seen. Intellectual functioning is aligned with strivings and goals. Anxiety is well-managed. The achievement drive is also consistent with the ability to implement goal-directed behaviour. Cognitive control is usually seen in terms of specific intellectual functions and capacities.

Ego controls. Integrative and control functions of the ego reflect goal orientation, a capacity to tolerate frustration, and an ability to implement activity toward goals.

Character traits. These are enduring patterns of control or patterns of behaviour. These characteristics may be separated into configurations of active traits versus those that can be considered passive traits. In compulsive characterology, active patterns are seen, while in passive characterology, passive patterns appear. Both types serve to control anxiety. Successful control would consist of character patterns that bind anxiety in a sustained, sufficient way. Such character patterns can be confused according to the following trait clusters:

* Sublimating traits involving the superego dimension include conscientiousness, studiousness, industriousness and responsibility. Sublimating traits reflect greater maturation.

* Impulse traits involving the id dimension include aggression, impetuousness and need for immediate gratification. Impulse traits reflect inadequate maturation.

* Pleasure-dominated traits include hedonism, magical thinking, need for immediate gratification, sociability, gregariousness, cordiality, seductiveness and optimism.

* Anger-dominated traits include aggressive and passive behaviour, hostility, oppositionalism, defiance, stubbornness, quarrelsomeness, sullenness and belligerence.

* Fear-dominated traits include caution, phobic reactions, shame, self-consciousness, timidity, pessimism and obedience.

* Dependency-dominated traits include deference, dependency and need for affection.

Fantasy as control. Mediates between feelings and behaviour and involves thinking instead of behaving. Control occurs through compensatory and grandiose feelings generated by fantasy. Success in fantasy neutralizes anxiety related to doubts regarding actually performing. Over use of fantasy implies a passive or schizoid orientation.

Fear as control. Appearance of phobias to control panic. A phobia is presumably a displacement of anxiety related to expression of anger or sexuality that is actually targeted toward another person. An impulse-dominated personality relates to immature development:

* A control-dominated personality reflects more mature development as well as pathology of inhibition.

Defensive structure. Signal anxiety or inner tension evokes the operation of a defense. Signal anxiety occurs in response to an internal threat (fantasies or impulses), or an ex-

ternal threat (other people or demands of life).

While the function of all these mechanisms is the same, i.e., to protect against painful feelings, they achieve this aim in different ways. For example, still another defense mechanism, turning against the self, does not ban the aggressive drive or impulse from consciousness as does repression: instead, it changes the object of the drive from another person to the self. It is operative especially in depression and masochism. Defense mechanisms rarely operate singly; they occur together, combined into an ever varying mosaic, cooperating with one another in order to achieve the goal of excluding from awareness what is unacceptable.

DEPERSONALIZATION: A disturbance in the sense of self usually experienced as a feeling of unfamiliarity in regard to one's own body or various of its parts. It is often reported by such phrases as ' I am surprised people recognize me' 'I don't like myself' 'I look at my hand and wonder to whom it belongs'. The basic content of depersonalization phenomena is that what should be familiar about the self is not.

DEREALIZATION: A feeling that the outside world, which should be familiar, seems unfamiliar and without emotional meaning. It is often reported by such phrases as 'I know you are my mother, but you don't seem like my mother'. The world is sometimes experienced as colorless, gray and drab. Not frequently, derealization occurs in conjunction with feelings of depersonalization. The experience should not be confused with boredom, apathy or depressive lack of interest.

DREAMS AND DREAMING: A universal and normal regressive phenomenon occurring during sleep in which thought processes and affects are represented in predominantly visual and (less frequently) auditory form. Other modes of sensory experience also occasionally participate in the dream including touch, smell and taste. It is a subjective experience, sometimes appearing banal superficially, but also often vivid and compelling. When associated with severe anxiety, the dream is described as a nightmare.

Dreams were originally described by Freud in The Interpretation of Dreams, one of the classical early works of psychoanalysis, as basically related to wish-fulfillment in their underlying or latent content. This understanding led Freud into some of his most important later concepts of psychoanalytic theory. Aspects other than wish fulfillment, such as mastery of infantile traumatic experiences, have been considered as additional psychological functions of the dream.

Dreaming and the formation of dreams, is considered to occur through the dream work, a mental process characterized by archaic methods of thinking (see primary process), particularly displacement and condensation, which transform the latent dream thoughts into the manifest dream. Two other less significant elements of the dream work are plastic and symbolic representation, the transformation of the thoughts into the sensory symbols and images (especially visual) and secondary elaboration, the linking together of the separate images and other elements of the dream into a relatively coherent story or action. In some instances, the latter does not occur and the dream is recalled as a disjointed, incoherent or bizarre series of images or phrases. Dream work is the agency responsible for the distortion of the latent content into the peculiar form and appearance of the manifest dream.

The manifest dream content is the dream as it is recalled by the dreamer with its associated images, speeches and sensory content as well as its specific formal aspects (including its division into parts, commentaries on the dream occurring within the dream etc.). Dreams occurring within one night - or the same sleeping period - are considered to be part of the same latent thought sequence.

The process of 'dream formation' is generally conceived as follows:

Because of universal regression and the relaxation of conscious and unconscious censorship during sleep, there is a revival of an archaic form of functioning which is epitomized in the dream work (use of the primary process mode of thinking). The effect of the dream work on the derivatives of infantile drives, defenses and their related conflicts as well as on their current representatives leads to the creation during sleep of predomi-

nantly visual images (the dream) to replace thought. A further step involved in dream formation is the contact between a day residue and the unconscious infantile drives and wishes of an erotic and aggressive nature. The resulting amalgam effectively disguises the infantile impulse which nevertheless remains the impetus for the dream. As mentioned above, to this disguise is added a process of distortion (including the secondary elaboration) accomplished by the dream work. The day residue is the dream's recent source material - elements from daily life which contribute to the formation of the dream. These events, impressions, perceptions, ideas and feelings from several days preceding the dream may in themselves be superficially trivial, but acquire their significance as dream instigators through their unconscious connections with the deeply repressed infantile conflicts or instinctual drives and wishes. The end result of this process occurring during sleep is the manifest dream.

It is now generally agreed, and confirmed by experimental evidence, that ex-tensive dreaming occurs during every sleep. Dreams, however, are often not remembered, are forgotten, or are recalled only in very fragmentary form. This complete or partial exclusion of dreams from conscious awareness is related to partly (not well understood) Physiological and partly psychological factors. The latter result from repression owing to anxiety or fears of social or moral disapproval of the ideas contained in them, or to unconscious censorship and resistance. Recall of forgotten dreams is often possible when the resistance is removed by analysis or by other means, such as hypnosis.

DRIVES: These are motivational forces which initiate behaviour. Freud conceived of two basic innate drives, sexual (libidinal) and aggressive and referred to them as the instinctual drives.

EGO-ALIEN: Not in consonance with the ego in relation to drives, affects, ideas or behaviour. The unacceptable mental contents are subjectively experienced by the observing ego as foreign to the self. Ego-alien is synonymous with ego-dystonic, the opposite of which is ego-syntonic. In these terms, ego is used in its earlier meaning, not the current structural one, to refer to what would now be called the self. However, self-alien or self-dystonic, though semantically logical, have not come into usage.

EGO AUTOMATICISMS: Normal ego automatisms are 'ego functions', usually involving motor activity, which are conducted without conscious attention being directed to them. They have become 'preconscious', i.e., not conscious, but easily made so. In this category is the mastery of tasks such as learning to drive an automobile or to play a game such as tennis, mastering a foreign language, etc. In pathological automatisms, the actions are determined by unconscious needs and do not appropriately conform to the reality of the situation. They occur in psychotic states such as schizophrenia (e.g., monotonous repetition of the same phrase [echolatia] or repetition of what another person says) and in fugue states (altered states of consciousness during which an individual may go through elaborate patterns of action without being aware of it).

EGO DEFECT: 1) A developmental incapacity or impairment in the ego adversely affecting the whole development of ego functions but specifically those concerned with psychic defense and adaptation.

2) A developmental impairment of specific and major ego functions characterizing cases of psychosis in infancy and childhood and also frequently found in adults with borderline or psychotic states.

EGO DEVELOPMENT: At birth the psychic apparatus is in an 'undifferentiated phase', which has the potentiality for id and ego development determined by hereditary and constitutional (innate) factors. What happens to the potential, however, depends greatly on the human beings surrounding the infant (the environment) and their capacity to love him for his own sake and not merely as an extension of themselves. In the course of ego development certain events mark its growth and are reflected not only in external behaviour but also in inner psychic states.

The infant is flooded by a mass of external stimuli of all varieties. Early in life these

might be intolerable were it not for the 'stimulus barrier', a physiologically less sensitive acuity to pain and other stimuli that exist in later life.

EGO-IDEAL: The image of the self to which the individual aspires both consciously and unconsciously and against which he measures himself. It is based on identification with the parents and other early environmental figures, as they actually are, were in the past, or as they have been idealized. To the extent that the actual self does not measure up to the ego ideal, the person's self-esteem suffers. The ego ideal is usually considered part of the superego.

EGO IDENTITY: The experience of oneself as having continuity and sameness, especially in relation to the ego's synthesizing function. Also includes the individual's views, ideals and standards, his behaviour and role in the society in which he lives. It is usually considered to be achieved developmentally during the normative crisis of adolescence.

EMPATHY: A special mode of perceiving the psychological state or experiences of another person. It is an 'emotional knowing' of another human being rather than intellectual understanding. To empathize means temporarily to share, to experience the feelings of the other person. One partakes of the quality but not the quantity, the kind but not the degree of the feelings.

Empathy does not contain the elements of condolence, agreement or pity essential for sympathy. One may participate in the joys and sorrows of another person in other various experiences, for example, as in the theatre; but the aim is quite different. Imitation and mimicry also bear some resemblance to empathy, but they are conscious phenomena limited to the external behavioural characteristics of a person.

The capacity for empathy is an essential prerequisite for the psychoanalytic therapist. Usually a preconscious phenomenon, it can be consciously instigated or interrupted. It can also occur silently and automatically and may oscillate with other ways of relating to people. The essential psychic mechanism is the analyst's partial and temporary identification with the patient.

Both empathy and intuition, to which it is related, are means of obtaining quick and deep understanding. Empathy establishes close contact in terms of emotions and impulses; intuition does the same in the realm of ideas. Empathy is a function of the experiencing ego, while intuition seems to be a function of the observing ego.

EROGENOUS ZONES: Anatomical areas of the body which are biologically determined components of the sexual apparatus. The component drives are intimately connected to their respective zones, which become triggers of sexual excitation and discharge as peripheral extensions of the psychosexual organization. The zones are called erogenous because the craving for gratification connected with the sexual drive is related to them. The zones may be used for auto-erotic satisfaction, but are important organs of contact with the love object. The psychobiological patterning and functioning of the erogenous zones have a profound influence on character development and symptom formation. Probably any area of the body (as well as the oral, anal and genital zones) may become secondarily invested as an erogenous zone. The psychosexual functioning of the erogenous zone is influenced by developmental and cultural factors. See psychosexual development.

EXTERNALIZATION: A term used to refer in general to the tendency to project into the external world one's instinctual wishes, conflicts, moods and ways of thinking (cognitive styles). It is evident in young children who are afraid of monsters in the dark, in the savage for whom the jungle is populated by evil spirits, and in the paranoiac who sees persecutors all about him. The capacity for externalization may be used constructively in art, poetry, literature etc. It is also the basis for the Rorschach test, which requires that an individual describe what he sees when he is presented with a series of standardized ink blots. The various shapes, forms and movements he sees reflect various aspects of his personality, from which the examiner can make deduction about tendencies of which the person is unaware.

FAMILY ROMANCE: A generic term for varied fantasies which have two central themes, usually associated but also appearing separate. One theme ennobles imagined instead of real parents, and the other involve a dramatic rescue in which the author may be rescued victim but is more usually the hero.

Freud and Rank made the basic contributions to the understanding of the structure and meaning of the family romance. The essence of the first theme, according to Freud, consists of the child's rejection of his own parents, with the fantasy that he is the offspring of other parents who are generally of nobler lineage than his real ones. These new, exalted and noble parents possess in the fantasy the identical idealized characteristics with which the child had endowed his own parents during his infantile period. The fantasy comes about as a result of the discrepancy between his idealized image and the real picture of his parents, stemming from the child's observations of defects in them. He is critical of them, dissatisfied with them or feels slighted by them. Thus disillusionment stimulates fantasy that helps to make acceptable the separation and estrangement from parents which is a necessary step in psychic development. Another function of the family romance fantasy is to lessen oedipal guilt by denying the incestuous quality of libidinal feelings toward the parents.

In the rescue fantasy the individual imagines himself saving the life of some very important personage, a king, emperor or other great man who is really a representative of a parent. In this way, Freud said, the child resolves his debt to his parents for having given him life. Oedipal wishes are in this instance dealt with by the defense mechanism of reaction formation at the same time that they are satisfied through placing the child in superior, omnipotent position to be helpful to the displaced parental figure. Rank widened the scope of the family romance as described by Freud by associating it with rescue fantasies relating both to the standard myth of the birth of the hero.

FIXATION: The tendency in psychic development for residuals of earlier phases to acquire and retain strong 'charges' of physic energy, and to play a significant role in later development of mental functioning. Arrests of development occur in both instinctual and ego-superego organization, permitting in various degrees the persistence of primitive ways of satisfaction, of relating to people and of reacting defensively to old, even out moded dangers. In addition to insufficiently known constitutional reasons for fixation (e.g., inherent differences in the functioning of the various erogenous zones and in ego 'givens'), there are inevitable experiences in which the developing, immature ego is overwhelmed by too much stress. These traumatic experiences usually involve an unfortunate combination of excessive satisfaction and excessive frustration. With disturbances of subsequent development and conflicts over contemporary functioning, regression is possible to these remnants of earlier functioning which are 'fixed' in the psyche. In his unconscious functioning, at least, the neurotic is 'pinned' or fixated to the past.

FREE ASSOCIATION: The method of thinking and reporting of the patient which is used as the basic procedure in psychoanalysis. The patient is asked to let his thoughts flow freely and to say everything that comes to mind without the selectiveness ordinarily dictated by social conventions. The type of thinking involved is similar to the thought processes engaged in while driving, shaving or in other semi-automatic tasks; the thoughts move freely from one topic to another, oscillating between fantasy and reality, without ever losing sight of reality entirely and occasionally sharply focusing on it. The difficulties in freely associating, common to almost everyone in the beginning. Such as blocking, evasion, and a disturbing discontinuity, become an important subject of analytic interpretation itself. These are 'resistances' which reflect the unconscious defenses employed to avoid awareness of disturbing material.

In the analytic process an observing function of the ego is encouraged. This is accomplished by the frequent focusing of attention and logical thought on the nature and meaning of the products of free association. Some patients have considerable difficulty in letting their thoughts roam freely, while others may succeed quite well in that task but not be able to achieve sufficient objectivity to observe the trend and meaning of associations, even with the help of the analyst. The ability to engage in both processes constitutes an important criterion for analyzability.

INDIVIDUATION: The maturational and developmental processes that occur from the latter half of the first year through the third year of life (separation-individuation phase), in which the intrapsychic representations of the self and the love object, the mother, are gradually differentiated. It is sometimes compared to a second birth experience, a 'hatching from the symbiotic mother-child common membrane'. An important step in the development of the sense of reality occurs when the mother-child omnipotent unity is relinquished. Psychotic disorders in childhood may be precipitated when predisposed children are faced with this step in development.

ID: Totally unconscious part of the mental apparatus which represents the sum total of most 'wishes' arising from the individual's needs, which in turn are indicated by their 'mental representations', that is, the instinctual drives. This implies that the instinctual drives are the essential 'components' of the structure id. However, it has been suggested that the id represented a broader concept that its most important component, the instinctual drives, and particularly more than its formulation as a 'chaotic cauldron' of mobile energy. The id maybe considered to be the result of interaction between innate and environmental factors and to include the sum total of 'wishes' which are the resultant of certain perceptions and memories of the earlier gratification of basic physiological needs.

IDENTIFICATION: An automatic, unconscious mental process whereby an individual becomes like another person in one or several aspects. It is a natural accompaniment of maturation and mental development and aids in the learning process (including the learning of speech and language), as well as in the acquisition of interests, ideals, mannerisms etc. An individual's adaptive and defensive reaction patterns are often attributable to identification with either loved and admired persons, or feared ones. By means of identification with a needed person, an individual can often provide for himself the satisfaction of the needs desired from that person. Separation from a loved person becomes more tolerable as a result of identification with him.

For identification to occur, sufficient psychic development must have taken place for the individual to distinguish himself from others in his environment. Such differentiation of self and object representations normally occurs in early childhood.

IDENTITY: The experience of the self as a unique coherent entity which is continuous and remains the same despite inner psychic and outside environmental changes. The sense of identity begins with the child's awareness that he exists as an individual in a world with outer objects and that he has his own wishes, thoughts and memories and his own distinctive appearance. Identification with both parents gives a bisexual quality to self-representations in children of both sexes. Eventually, however, an integrated self-representation (self-image) is created out of the multiple former identifications contributing to character traits. In respect of sexual identity, that self-image usually represents a predominant identification with the parent of the same sex. Relative stability of the sense of identity is achieved with the resolution of bisexual identifications and the completion of adolescence. The sense of identity is the self-image as perceived by one's self and entails awareness of some, though not all, physical sensations, emotional feelings and character traits. Personality, on the other hand, is the impression perceived by one's self and entails awareness of some, though not all, physical sensations, emotional feelings and character traits. Personality, on the other hand, is the impression perceived by others of the individual's physical appearance, affective expressions, modes of speech and behavior.

IMPULSE: The sudden, unpremediated welling up of an instinctual drive toward some action, which usually has the quality of hastiness and lack of deliberation. The term is applied either to physic awareness of the desire to act or to the action itself. Morbid impulses are further characterized by an irresistible and impelling quality in a setting of extreme tension where expression may be inappropriate. The impulse may be sudden and transitory or the associated tension may rise to a crescendo leading finally to uncontrolled expression (e.g., an exhibitionistic act). Frequently there is explosive and violent action with disregard for others and at times, for the subject himself.

The disturbances of impulse observed in a wide variety of so-called 'impulse disorders' have certain characteristics in common: 1) There is an understandable quality about the impulse. Distortion of sexual and aggressive wishes is not as marked as in classical neurotic symptoms. Usually its meaning is quite apparent to the observer, who empathetically realizes that it is the kind of phenomenon he could give expression to himself under comparable conditions. As a general rule, it is wholly or partly in harmony with the momentary aims of the psyche. Morbid impulses may be felt in the same way that common impulses are felt by 'normal' people. The morbidity is attributable to the irresistible quality, the manner in which the impulse is expressed or the fact that it is expressed in an unsuitable setting. 2) The impulse has a pleasurable component at the moment of expression even though the individual may criticize and despite himself for it. Sometimes horror is felt that he enjoys the act, which is experienced as happening against his will. See acting out impulse disorders.

IMPULSE DISORDERS: Aheterogeneous psychopathological group characterized by disturbances in impulse control. Addictions, perversion, impulse neuroses, kleptomania, impulsive psychopathic characters (i.e., character disorders) and even accident-proneness and fate neuroses are among the various clinical syndromes included in this group.

What these various conditions have in common is that the impulsive behaviour, not consciously perceived as abnormal, is both pleasurable and irresistible. It results from impairment of those normal ego functions which delay, modify and otherwise control the expression in behaviour of primitive impulses. The relative loss of control permits discharge of original, usually repressed, impulses in a minimally distorted fashion. In general, individuals suffering from these conditions are fixated at pregenital and preverbal stages of development; they have little tolerance for drive frustration as a result of identification with parental objects who provided inadequate models for the development of superego standards and prohibitions and ego controls.

Disorders of impulse control vary widely in symptomatology, psychodynamics, and genetic development and therefore do not constitute a distinctive special group of clinical conditions; however, they are frequently considered together because of the particular characteristics which they share in common.

INSTINCTUAL DRIVES: Freud's concept of a motivational force of human behaviour was, since the beginning of his theoretical formulations, one of the corner stones of psychoanalytic theory. He used for this concept the German word 'Trieb'. Before dealing extensively with various explanations and applications of this concept, Freud offered several definitions. His most cogent one was "... an instinct ... appears to us as a concept on the frontier between the mental and the somatic, as the psychical representative of the stimuli originating from within the organism and reaching the mind, as a measure of the demand made upon the mind for work in consequence of its connection with the body'.

This definition shows that Freud's concept of 'Trieb' is really a biological as well as a psychological one. Psychoanalysts vary in the emphasis they place on the biological or the psychological aspect. However, it has to be kept in mind that all such concepts are meant to be explanatory constructs. Such concepts as drive, psychic energy etc. are not meant to express something as well defined and quantifiable as physical or chemical energy.

Freud's definition refers to the psychic representation of internal stimuli. These stimuli represent physiological needs. Hunger, for example, illustrates the difference between such physiological processes as lowering of the blood sugar level, emptying of the stomach etc., and what eventually becomes the 'psychic representation' (which may be conscious, preconscious or unconscious). Of these physiological manifestations. What Freud had in mind when he spoke of 'Trieb' was the sum total of such mental representations of the various somatic needs. (As will be seen, this explanation will be important for our understandings of the concept Id).

Unfortunately the word 'Trieb', which Freud used for his concept, has usually been translated, especially by Strachey in his otherwise masterful Standard Edition, into

'Instinct'. The fallacy of this and the resulting confusion in the usage of this term is explained in the definition of the term 'instinct'. The instinct concept of biologists and students of behaviour conceptualizes a behaviour pattern and also includes the assumption of the movitational force which induces a special type of behaviour, while Freud's concept 'Trieb' tries to conceptualize only the motivational force.

We might ask why Freud's semantic formulation 'Trieb' was not simply translated as 'Drive'. The reluctance to do this was based on the following reasons: 1) The drive concept has been greatly abused of motivational forces called 'drives' is growing constantly; 2) Freud assumed that 'Trieb' are based on innate drives, which are, as preformed potentials, present at birth. This was one of the reasons why Strachey and others before him, chose the term 'instinct' as a translation. The term 'instinctual drives' express then, in its first word, an emphasis on the evolutional aspect of the concept 'Trieb', and avoids, on the other hand, the semantic pitfalls of the word 'instinct'. It is for these reasons that Hartmann, Rapaport and Schur, among others, have urged persistently the use of this term and suggested that the term 'instinct' be used only when we intend something analogous to the instinct concept of biology.

Freud attempted to conceptualise his theory of instinctual drives in different ways, trying first to find a general, all-encompassing term and eventually, arriving at his final formulation. It distinguished between 'Libido' or 'Eros' and 'Aggression', which he formulated in terms of what he called the 'Death Instinct'. Freud's concept of libido or eros is to be understood as the most general term for the much narrower term of sexuality. It encompasses all the processes, both physiological and psychological, which strive for synthesis, as well as all the positive aspects of human relationships and the factors which enter into the motivation of most human activities.

Freud's concept of the death instinct is his most controversial one and has been severely criticized both within and without the psychoanalytic field. Most psychoanalysts assume that this formulation is a highly speculative one, which thus far cannot be confirmed by any biological investigation. However, Freud's writings show his recognition that the death instinct can be observed only in aggressive, destructive actions directed either towards the environment or turned against one's own person. Most psychoanalysts therefore use, both in their clinical approach and in their writings, the concepts of the libidinal and aggressive instinctual drives.

INTELLECTUALIZATION: The psychological binding of the instinctual drives in intellectual activities, especially as a measure of control. This is exemplified by typical adolescent preoccupations with philosophy and religion. Under favourable circumstances, these trends may enrich knowledge and the intelligence, but pathological distortions create typical symptoms of obsessive and paranoid thought. Not infrequently intellectualization is used during the course of psychoanalytic treatment as a resistance against achieving emotional insight.

INTERNALIZATION: In its broadest aspect, a progressive process by which external interactions between the organism and the outer world are replaced by inner representations of these interactions and their and results. In an evolutionary sense, the mental apparatus and its physical substrata (including the instinctual drives) are structural records of the experiences of the race, substituting inner for out controls and thereby serving the purposes of self-preservation and propagation of the species, through their influence on superego formation. Social institutions may be considered elements in a biological frame of reference. Psychologically, memory (with symbol formation) and the anticipatory and decisional aspects of thoughts constitute the vehicles of internalization. Incorporation, introjection and identification are object-related mechanisms used for this purpose; projection and action are correlated externalizing processes.

INTERPRETATION: A form of intervention by the analyst, whose aim is to achieve therapeutic results by adding to the patient's knowledge of himself through making him aware of psychic content and conflict which had been warded off. In general, interpretations are dynamic or genetic in nature. Dynamic interpretations refer to psychic forces operating to produce a particular effect on mental life at any given time. Ge-

netic interpretations are concerned with indicating or clarifying the connections between past mental states and present ones. (Reconstruction may be considered as a special form of genetic interpretation, but is not identical. We reconstruct events, but we interpret meanings).

INTROJECTION: Originally used synonymously with the term identification. Recently it has been differentiated from identification and employed in two different contexts:

1) The assimilation of the object-representation into the self-representation whenever the boundaries between the self and object-representations are indistinct. The individual then becomes confused in regard to his separateness and even his identity.

2) The child's taking into himself as a psychic phenomenon the object's (usually parent's) demands as if they were his own, so that he reacts in the same way whether or not the object is present. The child does not copy the object as he would if he identified with it. The regulating, forbidding and rewarding aspects of the superego are formed by the introjection of parental directions admonitions and rewards.

LIBIDO THEORY: The theoretical description of a characteristic biological maturational sequence of libidinal phases from the oral to the mature genital phase. (See infantile sexuality). The theory assumes that the sources of the sexual instinct are derived from complicated somatic processes which exert a continuous demand upon the mental apparatus, an influence which is psychologically experienced as an impulse. There are component drives, usually associated with specific erogenous zones and phases (mentioned above) and typical wishes or fantasies. The drive organization is subject to progression, regression and fixation; it is normally organized under genital primacy after puberty. A latency period is postulated between infantile sexuality and post-pubertal genitality.

Freud's discovery of the significance of sexual desires in the formation of neurotic and psychotic symptoms necessitated an extensive exploration of the origin, development and vicissitudes of sexual drive influences from birth to old age. The study of these phenomena is called libido theory. The libido theory dominated psychoanalytic thinking and concept formation from Freud's first discoveries of unconscious motivations until the early 1920's, at which period the ego and its development began to share the interest of psychoanalytic psychology. However, as an explanatory principles the libido theory remains indispensable in psychoanalytic theory and practice, interrelating sexual drive organization with total personality development.

MASOCHISM: A propensity to seek physical or mental suffering in order to achieve, consciously or not, sexual arousal and gratification in the widest sense.

1) Sexual masochism appears early in childhood. Usually coupled with sadism as a 'partial drive'. (See infantile sexuality). Remnants of it persist in adult life as an attenuated component in forepleasure in many normal people, more often in women than in men.

2) Masochistic perversion is a condition in which sexual gratification is contingent upon physical or mental pain, such as beatings, threats, humiliations, imagined or actually experienced at the hands of the partner.

3) In moral masochism an unconscious or conscious need for punishment leads to symptoms, such as anxiety states or to unconsciously self-inflicted suffering. These manifestations can be shown to appear as a consequence of situations which normally would lead to satisfaction, rise of self-esteem, or happiness. This condition may lead to a type of therapeutic failure, known as negative therapeutic reaction.

4) Masochistic character or behavioural masochism, has in common with moral masochism that the sexual arousal and gratification bound up with suffering are unconscious. It differs from moral masochism by a prevalence of depressive moods and a tendency to complain about being the victim of the unfairness and malevolence of people and fate. Whereas moral masochism and behavioural masochism are mainly based upon an unconscious regressive sexualization of guilt feelings, the pathogenesis of masochistic perversion is based, in men, or unconscious passive homosexual tendencies; in both women and men, on the particular form and means of undoing childhood fears of castration, of rejection and of abandonment by the parents.

METAPSYCHOLOGY: A term first used by Freud to indicate that the assumptions of psychoanalytic psychology went beyond the scope of conscious experience to explain behaviour. It represents the highest level of abstraction in the continuum from clinical observation to psychoanalytic theory and serves as a conceptual tool for establishing an orienting and systematizing framework around which clinical data and lower-level psychoanalytic propositions can be organised. Since the academic psychology of the late 19th and early 20th century equated 'mental' with 'conscious', unconscious processes were considered outside the realm ofthe mind and hence 'beyond psychology' (the literal translation of metapsychology).

MATURE DEFENSE: Valliant called mature defenses correlate positively with normal coping reactions. Usually in the psychoanalytic literature mature defenses were lumped together under the heading of 'sublimation' or regarded so adaptive and conscious processes that they were viewed as coping mechanism and not defenses at all. For the user these mechanisms integrate conscience, reality, interpersonal relationship and private feelings. To the beholder they appear as convenient virtues. Under increased stress they may change to less mature mechanisms (see defense mechanisms grouping). Under the group IV, the mature defenese are Altruism, Humor, Suppression, Anticipation and Sublimation.

NARCISSISM: A concentration of psychological interest upon the self. This may range from healthy self-esteem and normal concern about oneself to pathological forms of brooding and to such severe degrees of self-preoccupation as that of the schizophrenic who stares at his image in the mirror or fantasies constantly about himself. Under normal circumstances, people's interests are divided between a concern for themselves (narcissism) and for the world of things and people around them (object love). Painful self-consciousness and an increased propensity for shame, are the outcome of conflicts over narcissism. On the other hand, pride and pleasure in one's own body and mind, one's achievements and in that part of the surroundings which the individual regards as his own, such as his family, his nation, and his possessions, may be regarded as manifestations of a healthy self-esteem. Injury to one's narcissism (e.g., blows to one's self-esteem) tends to evoke severe degree of anger, often referred to as narcissistic rage.

NEUTRALIZATION: A hypothetical psychic process whereby free ('unbound') instinctual energy, aggressive and libidinal, becomes modified and 'tamed'. Sublimation is now considered to be one example of the more general process of neutralization. The process of neutralization is significantly linked to the normal development of psychic structures - the ego and superego. Hence it has been proposed that a failure in this process would account for the impairment and defective development of the ego and superego in borderline states and schizophrenia.

OBJECT CHOICE: The conscious choice of a loved person, influenced strongly by unconscious determinants and o ffering gratification of certain instinctual drive demands. This selection may represent the choice of an individual who shares similar qualities with a loved object who offered gratification in infancy or childhood. Object choice has been further characterized as: narcissistic and anaclitic. In the former instance, an individual may choose someone who is like himself (embodying some characteristic of his own personality) or what he would like himself to be. An anaclitic object-choice refers to a choice based on the unconscious wish to receive passive gratification, i.e., to be symbolically fed and protected as the individual was by an object (usually the mother) at an earlier time. All of these determinants are often present in the unconscious choice of a loved person.

OBJECT LIBIDO: The energy of the sexual drive which is directed toward external loved objects (persons). Object libido is therefore sharply contrasted with narcissistic libido (the libidinal cathexis invested in the self). See libido.

OBJECT LOSS: 1) The actual loss of a loved person through separation, illness or death.

2) It may also refer to the experience of loss of love in the subject's inner world without the actual occurrence of the real loss or threat of loss of a loved person.

Thus, the fundamentally ambivalent instinctual attitude of a child toward his parents may lead him to experience (often by means of projection) a threat of loss of love. Also the individual's relationship to external objects may be repeated within the ego itself. For example, the experience of loss of love in depressive illness may have little to do with the patient's actual relationship with external love objects, but may reflect instead the reaction imposed by an extremely harsh superego. The experience of object loss may also result from a change in the internal psychic state as in a narcissistic regression

OBJECT LOVE: The type of love relationship with another person which occurs when that individual is cathected (invested) with libido. Originally, libido was invested in the self. Part of this narcissistic libido may be detached and transformed into object love. If such object love is based on the resemblance of certain attributes of the object to real or wishes for aspects of the self, it is said to be narcissistic in type.

OBJECT RELATIONS: Relationships taken in their broadest sense to include not only relations where there are direct instinctual gratifications (both libidinal and aggressive), but also relations where instinctual gratification is sulimated, as occurs in friendships and the love between parent and child. It is generally agreed that the capacity to love is a function that assumes increasing importance during normal maturation and development. There are individuals whose egos have been distorted or arrested in development and who evidence a stunted and immature capacity for object relations; this is characteristic of borderline and psychotic individuals. These more primitive forms of object relations have been described as transitional object relations and also as symbiotic object relations. Primitive object relations, on contrast to more mature forms of object love, are characterized by a relative inability to maintain the love relationship in the face of frustration and to accept the limitations and separateness of the loved object. Thus the child's attachment to his parents may be bonds of love, of hate, or of both (i.e., ambivalence), the last being by far more usual.

OBJECT REPRESENTATION: An enduring schema of a particular person other than the self modelled by the ego from a multitude of impressions, images and experiences with that person. A person recognized only because of his capacity to gratify instinctual needs is referred to as a need-satisfying object. Object representaion comes to exist when the schema exists, independent of such need satisfaction. For example, after the construction of the representation of the mother, the child perceives her as one and the same person even when he does not require her services (i.e., when she is sleeping, talking, walking, eating etc.). Together with the self representation it provides the material and framework for all mentation including the ego's adaptive and defensive functions.

OBJECT WORLD: The representation of external objects in the inner world of the subject's mind. They may correspond to actual experiences but are often altered by fantasy. Some authors contrast the various representations of loved objects with the representations of the self and refer to a 'self and object world'.

PLEASURE PRINCIPLE: One of what Freud called the'regulatory principles of mental functioning'. Freud at first used the term 'unpleasure principle' and then for many years 'unpleasure-pleasure principle' before he adopted, probably for reasons of simplicity, the term 'pleasure principle'. The pleasure principle regulates the need to recreate by action or by fantasy, any situation which has created the experience of satisfaction through the elimination of drive tension.

This principle, like the concepts 'instinctual drives' and the'id', has both biological and psychological connotations. The biological model for Freud's use of the term 'pleasure principle' was the 'constancy principle', a term coined by the father of experimental psychology, Fechner. This constancy principle and the pleasure principle as well, assumes that the organism seems to avoid or eliminate undue tension, which would disturb its equilibrium. Such an increase in tension is equated with unpleasure and the

elimination of tension with pleasure. The psychological concept similarly assumes that human beings strive for the achievement of gratification of various needs, equated with pleasure, as by unpleasure. Intolerable tension can arise either because of lack of satisfaction of wishes or because of external and internal danger situation which would occur if they were satisfied.

PREGENITAL PHASE: A term often misused for the prephallic phase which encompasses the oral and anal phases of development. Also prephallic phase is sometimes considered synonymous with preoedipal phase (since the phallic and oedipal phases overlap extensively and are often referred to as the phallic-oedipal phase).

PRE-OEDIPAL PHASE: The phase of childhood development that extends from birth to the formation of the oedipus complex (usually at 3 1/2 to 5 years). In contrast to the triangular situation in the latter, the pre-oedipal phase is characterized primarily by the attachment to the first love object, the mother. The drive vicissitudes involved are those of the oral, anal and phallic zones.

Some authors consider the phallic phase to overlap extensively with the oedipal, therefore refer to the phallic-oedipal phase. The polarity, active-passive, dominates the pre-oedipal phase. In normal development, at first there is an increasing identification with the mother, later vicissitudes depend on variations in sexual identification. The discovery of the sex difference becomes meaningful because of phallic masturbation toward the end of this period. The discerning and increasing conviction that the mother is castrated then ushers in the oedipus complex.

PRIMARY GAIN: The relief from emotional conflict and the freedom from anxiety achieved by a defense mechanism. The concept is that mental states, both normal and pathological, develop defensively in largely unconscious attempts to cope with or to resolve unconscious conflicts. All mental mechanisms operate in the service of the primary gain and the need for such gain may be thought of as responsible for the initiation of an emotional illness. To be distinguished from secondary gain.

PRIMARY PROCESS: In psychoanalytic theory, the generally unorganized mental activity characteristic of unconscious mental life. Seen in less disguised form in infancy and in dreams. It is marked by the free discharge of energy and excitation without regard to the demands of environment, reality or logic. (See also secondary process.)

PRIMARY SCENE: In psychoanalytic theory, the real or fancied observation by the infant of parental or other heterosexual intercourse.

PSYCHOANALYSIS: A branch of science developed by Sigmund Freud and his followers, devoted to the study of human psychological functioning and behaviour. It is usually considered to have three applications, referring to:

1) a method of investigation of the mind,
2) a systematized body of knowledge about human behaviour, and
3) a method of treatment of psychological or emotional illness.

PSYCHOANALYTIC THERAPY: (Synonymous with Psychoanalytically Oriented Psychotherapy): Psychoanalytic refers to concepts originated with S. Freud.With the advent of various forms of psychoanalytically oriented psychotherapy in addition to psychoanalysis, the issue of similarities and differences between them became complicated. Especially the development of ego-psychology and psychoanalytically oriented psychotherapy after Freud's time. Freud himself wrote that anyone who accepts the concepts of transference, resistance and the profound role of the unconscious can consider himself an analyst (later he himself had added more inflexible criteria by which the treatment should be called psychoanalysis). The psychoanalytic therapy is based upon when:

1) patient and therapist both are devoted to discerning the psychic truth behind the phenomena of transference, resistance and role of unconscious in the patient's present complaints and subjective distress,

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1) patient and therapist both are devoted to discerning the psychic truth behind the phenomena of transference, resistance and role of unconscious in the patient's present complaints and subjective distress,

2) they engage in a professional relationship (an analytical setting) characterized by a combination of professional code of ethics, intimacy and social abstention unlike any other form of human relationship,

3) the therapeutic alliance is towards insight development - in the origin and working through of intrapsychic conflicts than only reduction, modification or resolution of symptoms/maladaptive mode of defenses (unconscious) coping style (conscious).

PSYCHODYNAMICS: A body of knowledge and theory of human behaviour which attempts to explain the mental phenomena in normal and pathological conditions as a resultant of interacting and opposing goal-directed or motivational forces. As such, it focuses on the movement of these forces, illuminating processes, developments, progressions and regressions. For an understanding of psychodynamics. Psychoanalysis currently makes use of a 'structural model of the psychic apparatus, employing the concept of the id to represent the instinctual drives, the ego to represent the executive and inhibiting agencies and the superego to represent the influence of conscience and idealizations; all are manifested in any psychic phenomenon. The id tensions force the organism to seek satisfaction, i.e., the discharge of tension. The drive restraining forces of the ego operate to frustrate, delay or detour such discharge, either totally or until appropriate and safe conditions are available in reality. This opposition gives rise to intraphysic conflict; and the results of unconscious mental arbitration.

PSYCHIC APPARATUS: (Synonymous with mental apparatus): The hypothetical division of the mind on a dynamic and functional basis into various systems, agencies or groups of functions as a conceptual aid in understanding the psychological development and behaviour of human beings. It should be differentiated from the brain and its physiological activities and no specific localization in the brain or nervous system is intended.

The more recent view of the psychic apparatus, based on the structural theory, divides the apparatus into systems on the basis of the criterion: inner world (manifestations of the instinctual drives and the ego, both derived from the undifferentiated ego-id matrix) versus the outer world (external environment). The earlier psychoanalytic theory, known as the topographic hypothesis, divided the apparatus into systems on the basis of accessibility to consciousness: systems conscious and preconscious versus the inaccessible system of unconscious.

The growing understanding of mental functioning and a certain incompleteness in the topographic theory, led to the formulation of the structural theory, which divides the mind into several groupings of psychic functions. The major division of the psychic apparatus is into two parts:
1) the id, which is directly related to the instinctual drives and
2) the ego, a more coherent and organized agency which regulates or opposes the drives, mediating between them and the demands of the external world.

This division corresponds to our observations of mental function in situations of conflict. There is, however, a further division within the ego, called the superego, which separates off from the rest of the ego the moral and punitive functions and the ideal aspirations.

Thus, the psychic apparatus is divided into three groups of functions - id, ego and superego - which are often referred to as psychic 'structures'. Each of these psychic structures is more accurately understood as a group of mental contents (memory traces, memories, affective constellations, basic emotionally charged fantasies, organised thoughts, psychophysiological associations etc.) and processes which are functionally related to one another.

It must be emphasized that all mental activity (fantasy, thought, action or symptom) is the outcome of a mutual interaction among the tendencies of the id, ego and superego, combined with the influence of the external world. Psychic apparatus is the term used to refer to this total, more or less integrated, functional interaction which contributes to the final outcome of the human being's adaptation to the world.

Historically, Freud's original conception of the psychic apparatus compared it to 'dif-

ferent and successive systems of lenses of a telescope' in which preliminary images are formed where no tangible portion of the apparatus is located.

PSYCHIC DETERMINISM: (Psychic Causality): The doctrine that all present events are influenced and largely shaped by the past and specifically that under favourable conditions the determining factors for current human behaviour, symptomatology etc. can be understood in psychological terms. In other words, all psychic events and processes follow certain strict laws (though we may not understand these fully and form a lawful universe similar to that of the universe of physical events and processes.

PSYCHOSEXUAL DEVELOPMENT: The concept of psychosexual development resulted from Freud's examination of the origin and dynamics of neurotic symptoms. He recognized a regular sequence of libidinal manifestations beginning in early infancy and continuing to adulthood. The early phases, described under infantile sexuality, are centered on and organized around the oral, anal and later the phallic zones. These libidinal manifestations consist of pleasure giving activities, predominantly sucking (and later biting) at the oral phase, expulsion and retention of faeces during anal phase and finally manipulation (infantile masturbation) of the phallus (penis or clitoris) in the phallic phase. Each of these bodily activities is accompanied by more or less typical mental phenomena, connected mainly with objects of the child's surrounding world. Reference to these specific psychosexual stages therefore connotes more than the physical activity associated with it; also included are the psychic gratifications and frustrations, derivative mental and behavioural phenomena and the accompanying conflicts. The phallic phase, for example, highlights the significant differences between the sexes. It is typified by special interest in the naked body, curiosity about the opposite sex and a wish to look at (scopo-phillia) and to have the genitals seen (exhibitionism). In the female child, it is often marked by a sense of inadequacy about her genital organs, penis envy and competitive, masculine strivings. The conflicts arising from this period are predominately related to the oedipus complex, the resolution of which determines the choice of an object for genital satisfaction and the final sexual orientation and identification of the individual.

Childhood psychosexual development undergoes a typical arrest with the development of the castration complex in connection with oedipal fantasies. Beginning at about age six, a period of relative quiescence of sexual activity called latency, ensues. With the onset of puberty, psychosexual development is resumed, culminating, if successful, in the genital phase. Normally, after this stage is reached, the pleasures characteristic of the earlier infantile period are manifested in the sexual act only in so-called forepleasure. If the infantile pleasures remain the sole aim of sexual strivings in adults, the activities are often residual components in character structure and symptoms or more consecutively, they may contribute to professional and artistic achievement.

Derivative oral traits:

The need for immediate gratification.
Hostile-dependent behaviour: petulance, deference, depression and rage reaction.
Lowered self-esteem.
Magical strivings, grandiosity and compensatory behaviour.
Diagnostic syndromes include attitudes of the depressive type or the mood of the grandiose manic type.

Derivative anal traits:

Demand to perform, control and master.
The need for autonomy.
Behaviors and attitudes appear related either to cleanliness, rigidity, righteousness and reduced empathy or to acting-out, impulsivity, argumentativeness and impatience.
An objective, controlling approach or an impulsive, manipulative approach contribute to interpersonal strains.
Self-esteem is lowered by an accumulation of anger and resentments.
Diagnostic syndromes include the over control of the obsessive-compulsive or the dyscontrol of the acting-out or psychopathic type.

Derivative phallic traits:

Needs for assertion are denied, yielding passivity, or are expressed only through inappropriate overt anger.

Goals are sensed as inaccessible, contributing to lowered self-esteem and feelings of impotence.

Diagnostic syndromes include a passive-aggressive approach and narcissistic exhibitionism.

Derivative oedipal traits:

Conflicts regarding loyalty and sexual action-out with an experience of guilt in relation to disloyalty.

Ambivalence protects against involvement and commitment.

Competitive strivings and a sense of rivalry are overdeveloped or denied.

PSYCHO-SOCIAL DEVELOPMENT: A modification by Erikson of the psychoanalytic theory of psychosexual development giving more attention to the social and environmental problems associated with the various stages of development. He agreed some adult stages and their psychosocial crises viz., (i) birth through first year (trust vs. mistrust), (ii) through second year (autonomy vs. shame, doubt), (iii) third year through fifth year (initiative vs. guilt), (iv) sixth year to onset of puberty (industry vs. inferiority), (v) adolescence (identity and reperdiation vs. identity diffusion), (vi) early adult (intimacy and solidairty vs. isolation), (vii) young and middle adult (generativity vs. self-absorption), (viii) later adult (integrity vs. despair).

RECONSTRUCTION: An important type of intervention used in the course of psychoanalytic treatment. It consists of the analyst's attempt - one of his chief tasks - to correlate, understand and then convey to his patient (i.e., to reconstruct) forgotten, repressed, but psychologically important early experiences from the traces that they have left behind. Such traces gradually emerge in the patient's free associations, behaviour, dreams and transference reactions. The latter provide especially significant data for this form of intervention. Reconstruction is a gradual process, slowly and carefully advanced, which often leads to the further recall by the patient of repressed memories or other associations supplying new data for deeper understanding and interpretation. Reconstruction has been compared to the work of the archaeologist, who extrapolates a description of aspects of past civilizations from fragments and traces found in the present. Psychoanalysts, however, is now a more complex process than it was originally, when the recovery of the repressed memories of childhood traumatic experiences was the single most important occurrence in treatment. This is no longer true.

Nevertheless, reconstructions are still an essential part of psychoanalytic therapy because repressed early experiences are highly charged with emotional conflict. They have a serious impact on development and personality formation and play a major role in the origin and perpetuation of psychopathology. Thus the importance of reconstruction derives from the significance of the genetic (i.e., developmental) nature of psychoanalytic psychology, which stresses the historical roots of behaviour. The latter are often uncovered and understood by means of reconstruction.

REGRESSION: A concept which can best be described under two heading:

A. Libidinal Regression: A retreat to an earlier phase of instinctual organization, especially of the infantile period. Such a falling back occurs if, in the life process, a biologically predetermined maturational step presents the individual with difficulties which he is unable to master. Often this is determined by unresolved conflicts and anxieties at earlier phases which leave 'areas of weakness' in the preceding developmental phases (i.e., fixations) to which the individual is more likely to regress. A simple example of regression may be observed when, at times of emotional stress, a five year old child resumes thumb-sucking, a habit he had previously abandoned, or after engaging in genital masturbatory play, returns to anal masturbation. In childhood, when the development of sexual drives is still fluid, such regressions are ubiquitous (e.g., at times of illness or fatigue) and do not necessarily indicate pathology. Normal adults also show recurrence of archaic patterns of instinctual wishes and behaviour under certain conditions, such

is largely dependent on the mother for his survival and care and has not yet overcome his fear of losing her. In later childhood or adulthood, if excessive and inappropriate to the situation, separation anxiety represents a multi-determined symptom with a number of underlying meanings. One of these, excessive ambivalence toward the loved person, is invariably present and often the most significant. The absence of the loved person creates the possibility that unconscious hostile wishes may become fulfilled, and unrealistic anxiety causes. The presence of the ambivalently loved person serves as a reassurance against death wishes, since it is apparent that no harm has occurred.

SPLITTING OF THE EGO: Although the normal ego is essentially a relatively unified and organised group of functions, there are circumstances under which particular functions of the ego are set up against others, at least temporarily. For example, this occurs in the act of self-observation. One thinks, feels and acts subjectively, but at the same time observes such behaviour in a quasi-objective manner. In the psychoanalytic situation such a splitting of the ego is a regular and necessary occurrence. The interpretative action of the analyst helps the patient to become aware of and observe his own drive-directed or repitition of past attitudes and experiences (often repressed). Thus the ego is 'split' into sets of functions which can best be described as the observing aspect and the experiencing aspect. In this way, in therapeutic cooperation with the analyst, the patient can view his own activities and reactions while he is at the same time experiencing them, often with their full affective charge. This 'therapeutic split' of the ego is temporary and is replaced by integration of the previously unconscious material into the ego. More permanent ego dissociations are the cause of serious psychopathology (e.g., dual personality, fugue states, many forms of perversion and psychosis etc.)

STRUCTURAL THEORY: The currently accepted psychoanalytic theory of mental functioning which Freud advanced in 1923. It differs in its explanatory potential and in other significant ways, from the earlier topographic theory. (See psychic apparatus).

According to the structural theory, the mind (psychic apparatus) is divided into three functional groups which are called ego, id and superego. These are called 'structures' because of the relative constancy of their objectives and consistency in modes of operation. This division corresponds to what one can observe as to how the mind functions in situations of conflict over an instinctual drive. The major division is in two parts - one part, the id, is directly related to the instinctual drives, while the other, the ego, is more coherent and more organized. It regulates or opposes the drives, mediating between them and the demands of the external world. The structural theory makes a second division within the ego itself, separating from the rest of the ego certain moral functions, collectively called the superego.

SUPEREGO: A theoretical concept designating those psychic functions which, in their manifest expression, represent moral attitudes, conscience and the sense of guilt. It results from the internalization of the ethical standards of the society in which the person lives and develops by identification with the attitudes of parents and other significant persons in the child's environment. Superego functions may be divided into two categories: 1) the protective and rewarding functions, which set up ideals and values that are grouped under the term, ego-ideal; 2) the critical and punishing functions which evoke the sense of guilt and the pangs of conscience. In the structural theory, the superego is one of the three component parts or systems of the psychic apparatus. In neuroses, symptoms arise as compromises in the conflict between instinctual drives (id derivatives) and the forces seeking to forbid or restrain their expression (the superego). Such conflict is described as inter-systemic. See ego ideal, internalization, psychic, apparatus, structural theory.

SUPERVISORY TRANSFERENCE: Transference reactions are triggered by some aspect of the analytic situation. When transference reaction get triggered from the supervisory process in the analytical setting, it is called supervisory transference. The trainees often intercept the material of their supervisory session into analytic work with their patients even when it is not relevant and largely carried out as a part of his/her unresolved transference reactions. A big disadvantage in learning psychoanalytic technique from a handful of sources is that it increases the likelihood that the trainee will retain neurotic transference reactions (feelings and attitudes also) toward supervisor which will block

further exploration of ones own technique which can be best suited to ones personality and theoretical orientation.

SYMBIOSIS: A term introduced by Margaret Mahler in 1950 to describe the interdependent condition of the human infant and his mother, who creates a 'kind of social symbiosis' after birth, acting thereby as the child's protector or 'buffer', since she lacks an independent capacity for self-preservation. The term also refers to the stage of object or 'pre-object' relationship in which self and maternal intraphysic representations have not yet been differentiated. In symbiotic child psychosis there is a regression to a pathological form of this early phase of development.

SYMPTOM FORMATION: Psychoneurotic symptoms derive from unconscious psychic conflict arising from contending forces within the individual. These forces consist of repressed derivatives (unconscious fantasies, impulses and wishes) of childhood instinctual drives (both sexual and aggressive) - especially closely associated with the oedipal stage of development - and those psychic structures (ego, superego) which oppose the entrance of such derivatives into conscious thought or behaviour for moral or reality-adaptive reasons.

Such unconscious conflict is, however, universal and unavoidable; childhood instinctual conflicts may have other outcomes than symptom formation. For example, they may give rise to stable defensive patterns which play a major role in character formation; they may be sufficiently resolved to permit either a degree of acceptable direct gratification or a highly modified expression in useful sublimations.

Psychoneurotic symptoms thus permit the suffer to avoid some of the guilt and anxiety that a full, undisguised breakthrough of instinctual derivaties would produce.

Particular symptoms, and the specific illnesses characterized by them, arise from the complex variations in the nature of the neurotic conflict, the differences in instinctual forces and the defenses employed, the nature and intensity of the external stresses and traumas, the strengths and weaknesses of the psychic apparatus and its component parts, and the character structure and life experiences of the individual who falls sick.

TOPOGRAPHY: The special branch of psychoanalytic theory that attempts to classify mental operations and contents according to 'regions' in the mental apparatus. These regions are neither anatomical nor spatial, but rather are described according to their relationship to consciousness. Thus, a mental event (a wish, idea or feeling) that occurs outside of conscious awareness and cannot be made conscious by the effort of focusing attention, is said to occur in the 'deepest' region of the mind, 'the unconscious'. A mental event which can be brought to conscious awareness by an act of attention is said to be 'preconscious' which is hence not as 'deep' in the mind as the unconscious. Finally, there are mental events which occur in conscious awareness and are thus located on the 'surface' of the mind.

The topographical view point implies that a mental event and its contents have been described in terms of these 'regions'. In current psychoanalytic theory, the topographic hypothesis has been largely supplanted by the structural theory of the mental apparatus. However, the topographic system is still useful in describing the quality and degree of awareness of mental events and content.

TRANSFERENCE: The displacement of patterns of feelings and behaviour, originally experienced with significant figures of one's current relationship. This unconscious process thus brings about a repetition, not consciously perceived, of attitudes, fantasies and emotions of love, hate, anger, etc. under many different circumstances. The parents are usually the original figures from whom such patterns are displaced, but in many instances siblings, grandparents, childhood teachers and doctors may be contributing figures.

TRANSFERENCE NEUROSIS: Historically, this term was used by Freud to designate those psychoneuroses which are most amenable to treatment by classical psychoanalysis, namely hysteria, anxiety hysteria and obsessional neurosis. These were con-

trasted especially with the 'actual' neuroses and the psychoses, also called narcissistic neuroses by Freud.

In the modern terminology, transference neurosis is the new 'version' of the neurosis which develops in the course of psychoanalytic treatment, with the analyst as the focal figure upon whom the original childhood conflicts between instinctual drives and the defenses against them are now displaced.

UNCONSCIOUS: The quality of not being conscious or within mental awareness, typical of certain mental content or of the dynamic state of such content or processes. It may be described from several different standpoints:

A. Descriptive Unconscious: The aggregate of all mental contents and processes which at any given moment are outside of conscious awareness (or are 'unnoticed"). This of course includes all those contents of the mind which are 'preconscious'.

B. Dynamic Unconscious: Those mental contents and processes of the 'system' unconscious which are incapable of achieving consciousness because of the operation of a counterforce known as repression (or censorship). This force manifests itself during psychoanalytic treatment as a resistance to remembering.

Unconscious mental contents consist of drive representations and wishes, which are unacceptable, threatening or abhorrent to the normal, ethical and intellectual standards of the individual. They nevertheless strive continuously for discharge in behaviour or thought; this striving results in intrapsychic conflict and may produce feelings of anxiety or guilt. Should the counterforce of repression fail, the result maybe the formation of neurotic symptoms.

Mental contents which are unconscious are irrationally rather than logically organized around wishes or drives and strive for immediate discharge regardless of reality conditions. Thus we say that events in the dynamic unconscious are regulated by the primary process and the pleasure principle.

The dynamic unconscious is roughly coterminous with the structural system 'Id' but also includes important functions of the ego and superego.

C. The 'System' Unconscious: A region of the mental apparatus, topographically considered, in which memory traces are organized by primitive modes of associations (i.e., primary process). See consciousness preconscious, topography.

WORKING THROUGH: A term originally used by Freud to describe the continuing application of analytic work to overcome resistances persisting after the initial interpretation of repressed instinctual impulses. He explained this 'id resistance' as a likely occurrence in view of the fact that an instinctual process which has been going along a particular path for decades is suddenly expected to take a new path that has just been made open for it. It is the goal of working through to make insight effective, i.e., to bring about significant and lasting changes in the patient by altering the modes and aims of the instinctual drives. This leads eventually to the inclusion of warded-off components in the total personality. Now considered a most important part of the analytic process, working through consists essentially of a repetition, extension and deepening of the analysis of the resistances, which need to be overcome repetitively and progressively. Both the patient and the analyst contribute to this task; it maybe merely a repetition and elaboration of the usual analytic work or require special interventions in some cases. A special need for working through may exist when there has been a combination of traumatic experiences in early childhood and some event in latency which tends to organize and perpetuate the psychic reaction to the earlier trauma. Despite initial improvement, unless these traumatic events are thoroughly worked through, therapeutic changes will not be maintained and the patient will relapse.

YOGA: Patanjali the foremost exponent of yoga defines it as *'Chitta Vriti Nirodha'*; *chitta* is mind - which stands between man and his environment. It constantly reacts to sensory stimulation, ideas, thoughts, emotions and worries - even in the state of sleep. All these types of stimulations bombard the mind and create a whirlpool (*vritti*) within it.

'Nirodha' signifies control or restraint. In simple words it is a mental state of 'stopping all cognition'. The main purpose is to control the mind and keep it in a state of peace and tranquility. In order to attain this state, the seeker (*sadhaka*) first attempts at '*abhyasa*' (constant practice) and '*vairagya*' - a state where feelings are not affected by environment. He becomes '*sthith pragya*', one who is free of the five '*kleshas*' or afflictions, which are: '*avidya*' (ignorance), '*asmita*' (egotism), '*raga*' (personal likes or attachments), '*dwesha*' (personal dislikes) and '*abhnivesha*' (possessiveness). Yoga consists of eight steps. The first two are '*yama*' and '*niyama*', the third '*asana*', the fourth '*pranayama*', the fifth '*pratyahara*', the sixth '*dharma*', seventh '*dhyana*', the eighth '*samadhi*'. In the '*samadhi*', the *sadhaka* attains the transcendental state - a state of blissful trance, a supreme awareness in which the mind has transcended itself and has emerged with self embedded in truth.

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APPENDIX

SCORING SHEET: BIO-FEEDBACK TRAINING SESSION
E.GREEN, MENNINGER FOUNDATION, U.S.A.

Trainee's Intials _____ Date _____

Intial Index finger Temperature/Blood pressure _____

Meter Reading (at the start of each phrase)		Phrases
Left	Right	
_____		(1) I feel quite calm
_____		(2) I am beginning to feel quite relaxed
_____		(3) My feet feel heavy and relaxed
_____		(4) My ankles, knees and hips feel heavy, relaxed and at rest
_____		(5) My solar plexus, and the whole central portion of my body feels relaxed and comfortable
_____		(6) My hands, arms and shoulders feel heavy, relaxed and comfortable
_____		(7) My neck, jaws and forehead feel relaxed. They feel comfortable
_____		(8) My whole body feels quiet, heavy, comfortable and relaxed
_____		(9) Continue feeling relaxed for a minute
_____		(10) I am quite relaxed
_____		(11) My arms and hands are heavy and warm
_____		(12) I feel quite calm
_____		(13) My whole body is relaxed and my hands are warm and relaxed
_____		(14) My hands are warm

_____(15) Warmth is flowing into my hands they are warm, warm

_____(16) I can feel the warmth flowing down my arms into my hands

_____(17) My hands are warm, relaxed and warm

_____(18) Continue feeling relaxed for a minute

_____(19) My whole body feels quiet, comfortable and relaxed

_____(20) My mind is quiet

_____(21) I withdraw my thoughts from the surroundings and I feel serene and still

_____(22) My thoughts are turned inward and I am at ease

_____(23) Deep within my mind I can visualize and experience myself as relaxed, comfortable and still

_____(24) I am alert, but in an easy, quiet, inward-turned way

_____(25) My mind is calm and quiet

_____(26) I feel an inward quietness

_____(27) Continue feeling relaxed for a minute

_____(28) The relaxation and reverie is now concluded and the whole body is reactivated with a deep breathe and the following phrases: "I feel life and energy flowing through my legs, hips, solar plexus, chest, arms and hands, neck and head... The energy makes me feel light and alive." Stretch.

Final temperature_____ Final blood pressure_____

QUESTIONS: Answer before you look at your scores

1) What were your physical sensations as you went through the session ?

_____

2) What were your feelings and thoughts ?

_____

TEMPERATURE FEEDBACK TRAINING QUESTIONNAIRE

Your initials _____ Date_____ Time of Day_____

Where did you practice? _____ Starting skin temperature _____
(Highest Temp. Increase in Degrees F.____)

Were you able to feel the following internal changes?

a. Warmth Definitely Moderately Slightly Not at all
b. Flushing Definitely Moderately Slightly Not at all
c. Throbbing Definitely Moderately Slightly Not at all

_____

How did the training session seem?

_____

Were you able to relax? YES NO If not, what seemed to interfere?

_____

Mention the physical sensations that occurred

_____

Mention the emotional feelings that occurred

_____

Mention the thoughts, fantasies, and imaginings

_____

Did your mind wander at all? YES NO If yes,
A lot Moderately Slightly
Did you have any tendency to fall asleep (or get drowsy)? YES NO
Did you have any dream-like experiences or mental picture? YES NO
a. If so, did these experiences occur in a particular way?
Visual Auditory Spatial
Touch (Pressure) Smell Taste
b. If so, were you aware of these experiences all of a sudden (very quickly) or in a gradual way? Sudden Gradual

_____

Was there anything that you particularly liked or did not like about this training session?

_____

Any other experience you would like to share, or remarks you would like to make (if necessary please use reverse side of this sheet)

सम्प्रेषण पत्रः पुनः निवेश प्रशिक्षण सत्र

स्क्रीनिंगशीट : फीड बैक ट्रेनिंग सेशन

प्रशिक्षार्थी का नाम ता०

प्रशिक्षण शुरु करने से पहले का तापमान
प्रशिक्षण शुरु करने से पहले का रक्तचाप
तापमान

१ मैं काफी शान्ति (चैन) में हूं।
२ मैं अपने को काफी शिथिल (ढ़ीला) पाने लगा हूं।
३ मेरे पैर भारीपन और आराम महसूस कर रहे हैं।
४ मेरे टखने, घुटने और कूल्हे भारीपन, शिथिलता (ढ़ीलापन) और आराम महसूस कर रहे हैं।
५ मेरी शक्ति के स्रोत (सौर शक्ति नाड़ी-जाल) और शरीर के पूरे मध्य भाग में शिथिलता (ढ़ीलापन) और शान्ति (चैन) महसूस हो रही है।
६ मेरे हाथ, बाहें, और कन्धे भारीपन, शिथिलता (ढ़ीलापन) और आराम महसूस कर रहे हैं।
७ मेरी गर्दन, मेरे जबड़े और मेरा माथा शिथिलता (ढ़ीलापन) महसूस कर रहे हैं। वे अंग आराम से हैं और निर्विघ्न गति में हैं।
८ मेरा पूरा शरीर शान्ति (चैन) भारीपन, आराम और शिथिलता (ढ़ीलापन) अनुभव कर रहा है।
९ एक मिनट तक ऐसा ही अनुभव करिये।
१० मैं काफी शिथिलता (ढ़ीलेपन) में हूं।
११ मेरी बाहें और हाथ भारी और गर्म हैं।
१२ मैं काफी शान्ति (चैन) में हूं।
१३ मेरा पूरा शरीर शिथिल (ढ़ीला) हुआ और मेरे हाथ गर्मी महसूस कर रहे हैं। वे शिथिल (ढ़ीले) गर्म हैं।
१४ मेरे हाथ गर्म हैं।
१५ मेरे हाथों में गर्मी आ रही है, वे गर्म है, गर्म है।
१६ मुझे लग रहा है कि गर्मी मेरी बाहोंसे बहकर मेरे हाथों की ओर आ रही है।
१७ मेरे हाथ गर्म, शिथिल (ढ़ीले) और गर्म हैं।
१८ एक मिनट तक ऐसा ही अनुभव करिये।
१९ मेरा सारा शरीर शान्ति (चैन), आराम और शिथिलता (ढ़ीलापन) महसूस कर रहा है।
२० मेरा मन शान्त (चैन से) है।
२१ मैं अपने को वातावरण से हटाकर मन में बेहद शान्ति और स्थिरता महसूस कर रहा हूं।
२२ अपने मन को एकाग्र करके अब मैं शान्त (चैन से) स्थिर बैठा हूं।

२३ मैं इस एकाग्रता में, अपने आपको काफी शान्त (चैन से) शिथिल (ढ़ीला) और आराम करता हुआ देख सकता हूं और अनुभव कर रहा हूं कि मेरा मन बिल्कुल शान्त हो गया है।

२४ मैं सतर्क तो हूं पर किसी प्रकार की बाहरी हलचल मेरे चित्त में नहीं है और मैं इस एकाग्रता में शान्त (चैन से) हूं।

२५ मेरा मन शान्त और निश्चल है।

२६ मैं भीतरी शान्ति (चैन) अनुभव कर रहा हूं।

२७ एक मिनट तक ऐसा ही अनुभव करिये।

२८ यह आराम देने वाली काल्पनिक स्थिति खत्म हुई। एक लम्बी सांस लेने के बाद आपका सारा शरीर नई शक्ति अनुभव करेगा। लम्बी सांस लेते हुए इन शब्दों को मन में कहिये - "मैं अपने कूल्हों, पैरों, और शक्ति के स्रोत (सौर नाड़ी जाल) छाती, बाहों, हाथों गर्दन और सिर में एक ताज़गी और जीवन को बढ़ाने वाली शक्ति को बहते हुए अनुभव कर रहा हूं।
यह नई शक्ति मुझे ताज़गी और सजीवता दे रही है।
पसर जाइए।

प्रशिक्षण समाप्त करने के बाद का तापमान

अपने तापमान और रक्तचाप के अंकों को देखने से पहले इन प्रश्नों का उत्तर दें।

प्रश्न १ - इस सत्र (सैशन) को करते समय आपके शरीर में कौन सी संवेदना हुई लिखें, ____

प्रश्न २ - आपके मन में कौन से भाव और विचार आये थे, लिखें _____

तापमान पुन : निर्देश प्रशिक्षण - प्रश्नावली

आपका नाम ता० समय

किस जगह इस प्रशिक्षण का अभ्यास किया
प्रशिक्षण शुरू करने के पहले का तापमान

अधिकतक तापमान/कितने फा० अंशों में बढ़ा

क्या आपको निम्नलिखित आन्तरिक अनुभूति हुई (सही का निशान लगायें)

क.	गर्मी	निश्चित रूप से	मन्द रूप से	थोड़ा सा	बिल्कुल नही
ख.	चमक या लाल सा हो जाना।	____	____	____	
ग.	एकाएक धड़कना या फड़कना।	____	____	____	

आपको यह प्रशिक्षण सत्रा कैसा लगा, लिखें _____

क्या आप शिथिलता (चैन) महसूस कर पाये हां.....नहीं
यदि नहीं तो क्या अड़चन पड़ रही थी, लिखें _____

शरीर में जो संवेदनाएं हुई हों उन्हें लिखिये लिखें _____

मन में जो भाव आये हों उन्हें लिखिये _____

जो विचार, दिवास्वप्न या कल्पनायें आयी हों उन्हें लिखिये _____

क्या आपका मन जरा सा भी भटक गया था, हां नही
यदि हां तो, बहुत अधिक थोड़ा सा बहुत कम

क्या आपको नींद सी आने लगी थी (या पलकें झपक गयी थीं) हां नहीं

क्या इस बीच आपको स्वप्न जैसा दिखाई दिया था या कोई
कल्पना चित्र मस्तिष्क पर बनने बिगड़ने लगे थे हां नही

क. यदि ऐसा था तो क्या वे अनुभव किसी विशेष प्रकार की संवेदना से जुड़े हुए जेसे नीचे लिखें।

देखने से सम्बन्धित संवेदना	सुंनने से सम्बन्धिति संवेदना
स्थान से सम्बन्धित संवेदना	स्पर्श (दबाब) से सम्बन्धित संवेदना
गंध से सम्बन्धित संवेदना	स्वाद से सम्बन्धित संवेदना

ख. यदि हां तो क्या वे अनुभव आपको एकाएक (बहुत जल्दी) या धीरे-धीरे प्रतीत हुए थे
एकाएक धीरे-धीरे

इस प्रशिक्षण सत्रा की कोई विशेष बात आपको अच्छी लगी या अच्छी नही लगी उसको लिख कर बतलायें।

यदि आप अपना कोई अन्य अनुभव या इस प्रशिक्षण के विषय में कोई अन्य विचार हमें बतलाना चाहते हैं तो उसे लिखिये। (यदि नीचे जगह कम हो तो पन्ने के दूसरी ओर लिखिये।)

No meaning that comes from outside of ourselves is real,
The Buddahood of each of us has already been obtained.
We need only recognize it. Thus the Zen Master warns
his disciple: If you meet the Buddha on the Road
Kill him. In Psychotherapy and Existence: By Sheldon B. Kopp.
Also "we must always see our own A Bantam Book, U.S.A. 1973
feelings of uneasiness as being our chance for making the
growth choice rather than the fear choice" Abraham Maslow
In the way is not without danger. Everything good is costly, and the
development of the personality is one of the most costly of all things.
It will cost you your innocence, your illusion, your certainty

---

मेर्निजर फाउंडेशन, टोपेका कैन्सास के अनुसंधान विभाग के एलिसग्रीन तथा एलमेन ई० ग्रीन के स्कोरिंग शीट से अनुदित।
अनुवादक: डा० शकुन्तला दुबे तथा डा० दिनेश चन्द शर्मा

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